

Aging and Mental Health

Kacey Heekin
Larry Polivka

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The Claude Pepper Center
Florida State University

Executive Summary

Mental health is critically important throughout the life course. Mental illness in older adults is a prevalent condition that is associated with serious consequences. Recently, increased attention has been devoted to the existing geriatric mental health system as a result of the continuing growth of the older adult population and the current shortcomings in the way this system treats mental health issues in older adults.

This report examines many aspects of the national geriatric mental health system, with specific focus on geriatric mental health services in general and the geriatric mental health system in Florida. Some of the major findings in this report include:

- The number and proportion of older adults in the U.S. is growing, and a significant percentage of these individuals experience mental illness. Although the exact prevalence of geriatric mental illness varies by definition/source, according to Karel et al. 2012, approximately 20.4% of older adults experience a mental disorder. Common mental disorders in older adults include anxiety disorders, cognitive impairment, dementia, and mood disorders. Additionally, older men have the highest suicide rates in the country.
- Poor mental health in older adults has severe repercussions, including: compromised quality of life and physical health; higher mortality rates; increased hospitalization and nursing home placement; strains on interpersonal relationships; and large societal costs.
- Several of the issues regarding mental health in general are especially relevant to older adults, such as: difficulty in the recognition/diagnosis of mental disorders; the presence of distinctive life stressors (e.g., physical impairment, loss of a loved one, and financial issues); medication complications; a lack of funding; service delivery fragmentation; and deficits in prevalence of mental disorders and utilization of mental health services data.
- Often, geriatric mental health issues go untreated. Research indicates that older adults with mental disorders are less likely than younger and middle-aged adults to receive mental health services, especially from mental health specialists (many older adults receive mental health care in primary and long-term care settings). The barriers that older adults face to getting proper care include stigmatization associated with mental/emotional issues, lack of information about available services, lack of transportation, lack of money or insurance to pay for services, and an inadequate geriatric mental health workforce.
- A variety of services are required to meet the nation's geriatric mental health needs, including prevention, screening, diagnosis, treatment, and monitoring. Providing better access to home and community-based geriatric mental health services and integrating primary care and other mental health services are critical. Numerous system-based interventions (models of care) have proven effective for managing geriatric mental health.
- Mental illness is one of the costliest conditions in older adults; the costs associated with poor geriatric mental health, especially Alzheimer's disease, are projected to grow exponentially. Research indicates that prevention, early diagnosis, and pharmacological and psychosocial treatments are generally cost-effective in older adults with mental health issues. Integrated care is also particularly cost-effectiveness in this demographic.
- Recent legislation that has supported improvements in the geriatric mental health system include the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act of 2010. These policies have helped to create parity for

coverage of mental health services with physical health services, expand coverage for populations prone to mental health issues, improve coverage of Medicare Part D, support preventative care/screenings, and integrate health services. Additionally, the National Alzheimer's Project Act of 2011 was enacted to address this major public health concern.

- Florida has one of the largest populations of older adults in the U.S., thus this state's geriatric mental health system is especially important. However, in Florida, funding levels have consistently failed to meet the growing need for services, with Florida maintaining one of the lowest per capita mental health expenditure rates in the nation.
- The Florida Department of Children and Families, which is responsible for state mental health services, and the Department of Elder Affairs, which is responsible for administering state services and programs to benefit Florida's older adults, are working to improve the geriatric mental health system by supporting several priorities, including: evaluating the needs of Florida's older adult population; pursuing the expansion of community-based services (e.g., Community Action Teams); coordinating care; strengthening the geriatric mental health workforce; and diverting individuals with mental health issues who become involved with criminal justice system.
- Improvements in the current geriatric mental health system are imperative. There is a need for continued research on the diagnosis, etiology, and treatment of geriatric mental illnesses (especially dementia), comparative research on cost-effectiveness of different geriatric mental health interventions, implementation of evidence-based practices and integrated care, multicultural competency in geropsychology, development of the geriatric mental health workforce, and restoration or expansion of mental health budgets.

Section 1. Introduction

Mental health is a critical issue throughout the aging process. Mental illness in older adults is a prevalent condition that can have serious repercussions on an individual's physical health and quality of life; mental illness in older adults is also costly and has major economic implications. Moreover, many of the issues surrounding mental health in older adults are unique to individuals within this demographic and the source of complications in the way that the current mental health system recognizes, diagnoses, and treats mental illness in older adults. Geriatric mental health services and interventions should be understood and developed and/or modified accordingly. Recently, increased attention has been devoted to the analysis of aging and mental health and the existing geriatric mental health system. This consideration has become more urgent with the continuing growth of the older adult population.

Section 2. A National Perspective on Aging and Mental Health

The number and proportion of older adults in the U.S., and in industrialized nations at large, is growing, especially as life expectancy increases and fertility decreases. According to a recent report by the Institute of Medicine (2012):¹

The U.S. Census Bureau projects that the number of adults age 65 and older will increase from 40.3 million to 72.1 million between 2010 and 2030. (Institute of Medicine, 2012, p. 1)²

A significant percentage of older adults in the U.S. experience mental illness. The exact prevalence of mental illness in older adults varies by definition and source. The Institute of Medicine (2012)³ report states:

The committee estimates that in 2010, at least 5.6 to 8 million older adults had one or more MH/SU conditions. Several million more older adults were probably also affected, but the available data are not adequate to estimate the number. (Institute of Medicine, 2012, p. 39)⁴

It is important to note that the mental health and substance use (MH/SU) conditions considered in this report exclude the principal diagnoses of cognitive impairment (e.g., Alzheimer's disease other dementias), intellectual disability, and autism spectrum disorder. However, the behavioral and psychiatric symptoms of dementia are included.⁵

A report by Karel et al. (2012)⁶ states:

¹ Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?*. Washington, DC: The National Academies Press.

² Ibid.

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ Karel, M. J., Gatz, M., & Smyer, M. A. (2012). Aging and mental health in the decade ahead: What psychologists need to know. *American Psychologist*, 67(3), 184-198.

Our analysis of the most recent available data indicates that an estimated 20.4% of adults 65 years of age and older met criteria for a mental disorder, including dementia, during the previous 12 months. (Karel et al., 2012, p. 185)⁷

Although the overall prevalence of mental illness in older adults is somewhat similar in magnitude to that of other age groups, including middle age adults, the distribution of the specific mental illness conditions that are experienced by the older adults can differ.⁸ Karel et al. (2012)⁹ specifies:

Older adults are more likely to develop dementia, including Alzheimer's disease, but have lower prevalence of anxiety, mood, impulse-control, and substance use disorders compared with other adult age groups. There is variation in disorders across the older adult age range. Incidence of dementia increases exponentially across the older years; few experience onset before the age of 60 years. Prevalence of depression tends to be lower with each succeeding decade of age, although rates take a slight upturn in those 85+ years old. (Karel et al., 2012, p. 185)¹⁰

It is expected that as the number of older adults continues to increase, so too will the number of older adults experiencing mental health issues. The Institute of Medicine (2012)¹¹ predicts that by 2030, the number of older adults with MH/SU conditions will increase by 80%.

Certain mental disorders/conditions are more common in older adults than others. According to the Centers for Disease Control and Prevention and National Association of Chronic Disease Directors (2008),¹² the most common mental health conditions among individuals age 55 years or older are anxiety, severe cognitive impairment, and mood disorders (e.g., depression and bipolar disorder). The Institute of Medicine (2012)¹³ confirms that:

Depressive disorders and dementia-related behavioral and psychiatric symptoms are the most prevalent. Serious mental illness-including schizophrenia and bipolar disorder-is less common, but has significant implications for the workforce and care delivery. (Institute of Medicine, 2012, p. 4)¹⁴

Analysis within this Institute of Medicine (2012)¹⁵ report reveals that 12-month prevalence rates and estimated number of community-living adults age 65 and older in 2010 with depressive disorders was 1.2-1.8 million, with social phobia, 0.4-1.0 million, with posttraumatic stress disorder, 0.2-1.0 million, with generalized anxiety disorder, 0.4-0.8 million, and with alcohol dependence or abuse, approximately 50 thousand to 0.7 million. This report also reveals that the

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Institute of Medicine, supra, note 1.

¹² Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. (2008). *The state of mental health and aging in America issue brief 1: What do the data tell us?*. Atlanta, GA: National Association of Chronic Disease Directors.

¹³ Institute of Medicine, supra, note 1.

¹⁴ Ibid.

¹⁵ Ibid.

prevalence and estimated number of nursing home residents age 65 and older in 2009 with depression was 590,834, with anxiety disorders, 192,071, with bipolar disorder, 33,416, and with schizophrenia, 42,521.

Empirical findings on the exact overall prevalence of specific mental disorders in older adults also show varying results. A recent study by Volkert et al. (2013)¹⁶ reports:

Thus far, no meta-analysis on the prevalence of mental disorders in older people exists. Accordingly, the primary aim of this study was to assess the prevalence of mental disorders in older people in the general population of Western countries, specifically Europe and North America.

Disorders with the highest prevalence ratios were dimensional depression (19.47%) [dimensional depression was defined as depressive disorders diagnosed with the use of cut-off scores on self-rating questionnaires], lifetime major depression (16.52%), and lifetime alcohol use disorders (11.71%). Disorders with the lowest estimates were current and lifetime drug use disorders (0.34% and 0.19%, respectively), and current bipolar disorder and current agoraphobia (both 0.53%). (Volkert et al., 2013, p. 339-340)¹⁷

Dementia, mainly Alzheimer's disease, is a very prominent mental health issue in older adults. According to the *2013 Alzheimer's Disease Facts and Figures* report,¹⁸ approximately 13.9% of people age 71 and older in the U.S. had dementia in 2013, based on estimates from the Aging, Demographics, and Memory Study (ADAMS). Furthermore, this report discloses:

An estimated 5.2 million Americans of all ages have AD in 2013. This includes an estimated 5.0 million people age 65 and older and approximately 200,000 individuals younger than 65 who have younger-onset AD. (Alzheimer's Association, 2013, p. 215)¹⁹

Therefore, approximately one in nine people age 65 and older (11%) has Alzheimer's disease (AD), and about one-third of people age 85 and older (32%) have AD.²⁰ It is also important to note that dementia has a high rate of comorbidity with other mental disorders. Specifically, individuals with dementia or mild cognitive impairment have increased rates of depression, anxiety, and other behavioral disturbances.²¹

¹⁶ Volkert, J., Schulz, H., Härter, M., Włodarczyk, O., & Andreas, S. (2013). The prevalence of mental disorders in older people in Western countries—a meta-analysis. *Ageing research reviews*, 12(1), 339-353.

¹⁷ Ibid.

¹⁸ Alzheimer's Association. (2013). 2013 Alzheimer's disease facts and figures. *Alzheimer's & dementia: The journal of the Alzheimer's Association*, 9(2), 208-245.

¹⁹ Ibid.

²⁰ Ibid.

²¹ Karel et al., supra, note 6.

The prevalence of severe mental illness (SMI) in older adults is estimated by the Institute of Medicine (2012)²² to have been approximately 1.5 to 4.8% of the older adult population in 2010, affecting around 611,000 to 1.9 million older adults.

Additionally, suicide is prevalent in this population. Older men have the highest suicide rates in the nation.²³ Suicide can be, and is often, a result of depression. The 2008-2010 death rate per 100,000 for fatal injuries due to suicide in the U.S., according to the Centers for Disease Control and Prevention's (CDC) Web-based Inquiry Statistics Query and Reporting System (WISQARSTM), for all ages was 12.10; the rate for men age 65 and older was 29.08 and 43.84 for men age 84 and older.²⁴

Overall, prevalence data on the specific state of mental health in older adults remains elusive, but the general consensus is that mental illness/conditions are prominent in this population.

Section 3. Impact of Poor Mental Health in Older Adults

Poor mental health in older adults has severe physical, economic, and social consequences. Geriatric mental illness is associated with compromised physical health. For example, research has indicated that depression in older adults is associated with greater risk of poor outcomes after hip fracture, increased risk of coronary heart disease, and even a generally increased risk of cancer.^{25;26;27} Mental illness is also associated with an increased risk of co-morbid chronic disease in older adults. A study by Lin et al. (2011)²⁸ reports that community-dwelling older adults with mental illness or substance use disorders had substantially increased adjusted risk for various chronic physical conditions, including hypertension, ischemic heart disease, congestive heart failure, atrial fibrillation, stroke, chronic obstructive pulmonary disease (COPD) or asthma, diabetes mellitus, chronic kidney disease, osteoporosis, arthritis, hip or pelvic fracture, cancer, dementia, and Parkinson's disease, than individuals without these disorders.

Mental illness in older adults is also associated with increased mortality rates. According to the Institute of Medicine (2012):²⁹

²² Institute of Medicine, supra, note 1.

²³ Centers for Disease Control and Prevention & National Association of Chronic Disease Directors, supra, note 12.

²⁴ Web-based Injury Statistics and Query Reporting System (WISQARS) (Online). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). Available at: <http://www.cdc.gov/injury/wisqars/index.html> (accessed July 10, 2014).

²⁵ Givens, J. L., Sanft, T. B., & Marcantonio, E. R. (2008). Functional recovery after hip fracture: The combined effects of depressive symptoms, cognitive impairment, and delirium. *Journal of the American Geriatrics Society*, 56(6), 1075-1079.

²⁶ Brown, J. M., Stewart, J. C., Stump, T. E., & Callahan, C. M. (2011). Risk of coronary heart disease events over 15 years among older adults with depressive symptoms. *The American Journal of Geriatric Psychiatry*, 19(8), 721-729.

²⁷ Penninx, B. W., Guralnik, J. M., Havlik, R. J., Pahor, M., Ferrucci, L., Cerhan, J. R., & Wallace, R. B. (1998). Chronically depressed mood and cancer risk in older persons. *Journal of the National Cancer Institute*, 90(24), 1888-1893.

²⁸ Lin, W. C., Zhang, J., Leung, G. Y., & Clark, R. E. (2011). Chronic physical conditions in older adults with mental illness and/or substance use disorders. *Journal of the American Geriatrics Society*, 59(10), 1913-1921.

²⁹ Institute of Medicine, supra, note 1.

People of all ages with MH/SU conditions experience higher mortality rates than other people without these conditions. Their higher mortality can be attributed to many factors, including poor compliance with prescribed medical treatments for physical health conditions; toxic effects of medications prescribed for their MH/SU condition; negative health behaviors, such as excessive use of alcohol and drugs, smoking, and inactivity; poor-quality medical care; poverty; lack of health insurance; and lack of coordination in the medical and specialty MH/SU systems. (Institute of Medicine, 2012, p. 109)³⁰

A recent meta- review by Chesney et al. (2014)³¹ of 20 relevant reviews that report mortality risks in 20 different mental disorders reveals that all of the studied mental disorders had an increased risk of all-cause mortality compared with the general population. Many of these mental disorders even had mortality risks larger than or comparable to that of heavy smoking.³² Another recent study by Wu et al. (2014)³³ reports that cognitive impairment, which was assessed at the participants' annual geriatric health examinations, is associated with an increased risk of mortality.

Mental illness in older adults is also associated with an increased risk of hospitalization, nursing home placement, and poorer quality of life. Such outcomes can be both very costly and create strains on interpersonal relationships. Dementia alone is responsible for the hospitalization of many older adults.

People with AD and other dementias have more than three times as many hospital stays per year as other older people. (Alzheimer's Association, 2013, p. 228)³⁴

With increased risk of hospitalization, the issue of delirium must also be recognized. Delirium is a disturbance in an individual's mental abilities which is often characterized by inattention and acute cognitive dysfunction. Fong et al. (2009)³⁵ reports that in the community, the prevalence of delirium is 1-2%, but in general hospital admission settings, the prevalence rises to 14-24%. Furthermore, this study also reveals that delirium affects approximately 14-56% of hospitalized older adults.³⁶ Delirium is thus a substantial mental health problem in hospitalized elderly patients. However, Fong et al. (2009)³⁷ also reports:

An estimated 30-40% of cases of delirium are preventable, and prevention is the most effective strategy for minimizing the occurrence of delirium and its adverse outcomes. Drugs such as benzodiazepines or anticholinergics and other know

³⁰ Ibid.

³¹ Chesney, E., Goodwin, G. M., & Fazel, S. (2014). Risks of all-cause and suicide mortality in mental disorders: A meta-review. *World Psychiatry, 13*(2), 153-160.

³² Ibid.

³³ Wu, C. Y., Chou, Y. C., Huang, N., Chou, Y. J., Hu, H. Y., & Li, C. P. (2014). Cognitive impairment assessed at annual geriatric health examinations predicts mortality among the elderly. *Preventive medicine, 67*, 28-34.

³⁴ Alzheimer's Association, supra, note 18.

³⁵ Fong, T. G., Tulebaev, S. R., & Inouye, S. K. (2009). Delirium in elderly adults: Diagnosis, prevention and treatment. *Nature Reviews Neurology, 5*(4), 210-220.

³⁶ Ibid.

³⁷ Ibid.

precipitants of delirium should generally be avoided. In addition, benzodiazepine or alcohol withdrawal is a common preventable cause of delirium.

The Hospital elder life Program (HELP) is an innovative strategy of hospital care for elderly patients that uses tested delirium prevention strategies to improve overall quality of hospital care. (Fong et al., 2009, p. 214)³⁸

Fong et al. (2009)³⁹ concludes that delirium results in a substantial economic burden, with increased delirium-associated costs estimated at \$2,500 per patient per hospitalization and totaling approximately \$6.9 billion in medicare hospital expenditure based on 2004 data, and that appropriately managing delirium is thus critical.

As previously mentioned, mental illness in older adults is also associated with poorer quality of life. The Institute of Medicine (2012)⁴⁰ confirms that:

Studies that have used structured assessment of quality of life or health-related quality of life also show that MH/SU conditions, including depressive disorders, depressive symptoms, generalized anxiety disorder, and substance use disorders, are associated with reduced health-related quality of life. (Institute of Medicine, 2012, p. 109)⁴¹

Mental illness in older adults has major economic impacts. The costs associated with geriatric mental health are very substantial.

The 2009 Medical Expenditure Panel Survey (MEPS) found that 7.4 million adults age 65 and older received services for mental disorders at a cost of \$17.1 billion, making mental disorders the eighth most costly condition for adults age 65 and older in the United States in 2009. (Institute of Medicine, 2012, p. 110)⁴²

Considerable evidence shows that older adults with MH/SU conditions are among the most costly Medicare beneficiaries. (Institute of Medicine, 2012, p. 23)⁴³

The costs associated with poor mental health in older adults are projected to grow as this population continues to expand. For example:

As the number of people with AD and other dementias grows, spending for their care will increase dramatically. For people with these conditions, aggregate payments for health care, long-term care and hospice are projected to increase from \$203 billion in 2013 to \$1.2 trillion in 2050 (in 2013 dollars). (Alzheimer's Association, 2013, p. 227)⁴⁴

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Institute of Medicine, *supra*, note 1.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Alzheimer's Association, *supra*, note 18.

Mental illness in older adults has major social impacts. Geriatric mental illness can cause strains on relationships with friends, family members, and/or partners of the afflicted individual. This strain can be instigated by caregiver burden and increased isolation of the older adult with mental illness. Geriatric mental illness can also influence the ways in which society interacts with the older adult population at large. Misconceptions can result in bias, stigmatization, and reduced access to appropriate and effective care.

Section 4. Issues Surrounding Aging and Mental Health

Many of the issues regarding mental health in older adults are unique to individuals within this demographic. For instance, the diagnosis of mental disorders in older adults can be especially difficult because certain mental conditions can present as/cause symptoms of multiple disorders. Specifically, distinguishing between the diagnoses of depression, delirium, or dementia can be complicated. Furthermore, certain symptoms of mental illness can be mistaken as simply symptoms of aging. The symptoms of depression in older adults can be confused as signs of dementia, arthritis, cancer, heart disease, Parkinson's disease, stroke, and thyroid disease.⁴⁵ The presentations/symptoms of mental disorders in older adults can also differ somewhat from symptoms in younger populations.

Older adults can encounter unique, age-related life stressors. Examples of these sorts of stressors include illness, physical impairment, loss of a loved one, retirement, financial issues, and changes in environment. Many older adults are also burdened with chronic diseases and related disability. Often times these stressors can instigate symptoms of mental illness.

The etiologies of mental disorders in older adults can also differ. The onset of the specific disorder can be indicative of the etiology of the condition. For example, early-onset depressive and bipolar symptoms are more likely to be due to genetic contributions than late-onset symptoms. Such differences can influence the type of preventative services, and even treatments, that might be most effective for geriatric mental health.

Despite the high prevalence of geriatric mental disorders, older adults often experience less access to mental health services.

Large-scale, population-based surveys conducted over the past 30 years in the United States have found that only small proportions of older adults with MH/SU conditions receive any services for these conditions. (Institute of Medicine, 2012, p. 124)⁴⁶

Multiple data sources confirm that older adults with evidence of mental disorders are less likely than younger and middle-aged adults to receive mental health

⁴⁵ National Alliance on Mental Illness. (2009). *Depression in older persons: Fact sheet*. Arlington, VA: National Alliance on Mental Illness.

⁴⁶ Institute of Medicine, *supra*, note 1.

services and, when they do, are less likely to receive care from a mental health specialist. (Karel et al., 2012, p. 187)⁴⁷

The barriers that older adults face to receiving proper mental health care can vary. Stigma associated with mental and emotional issues, especially in this current cohort of older adults, has been suggested as one such barrier. The Institute of Medicine (2012)⁴⁸ proposes:

Other factors, such as lack of information about available services, lack of age- and culturally and linguistically appropriate services, lack of transportation, and lack of money or insurance to pay for services, undoubtedly reflect current reality. (Institute of Medicine, 2012, p. 123)⁴⁹

Older adults can experience medication complications that are relevant to mental health. Older adults take more medications than any other age group. There is much controversy surrounding the issues of whether older adults are taking too many medications and if this overmedication results in overall negative health outcomes. One example of a specific setting in which certain health care professionals argue that older adults are being overmedicated is nursing homes, especially in relation to the usage of antipsychotics. Medication complications can include drug side effects and drug-drug interactions. Certain medications can even induce cognitive impairment. Not only can medication complications create health-related problems for older adults, but mental health issues, such as depression, delirium, dementia, and anxiety, can influence medication taking behaviors. Additionally, older adults tend to be more sensitive to pharmacological treatments, due to metabolic changes, so specific research is always needed to verify the safety of pharmacological treatments in this population. Health care providers must be aware of all medications being taken by their elderly patients in order to prevent serious medication complications.

One of the greatest issues surrounding aging and mental health is the inadequate workforce of trained geriatric mental health providers. There is a lack of national attention to ensure enough providers for the growing older adult population. The Institute of Medicine (2012)⁵⁰ confirms the magnitude of this problem. Additionally, current health care providers are not always familiar with the signs of mental illness in older adults. Primary physicians need to be aware of and able to recognize mental health problems, especially in older adults, and subsequently able to offer treatment or other resources to relevant individuals.

... At present, psychologists who identify geropsychology as a focus of their work are commonly employed in private and group practices that, at least historically, are settings of care that older adults are much less likely to visit. (Karel et al., 2012, p. 188)⁵¹

Furthermore:

⁴⁷ Karel et al., *supra*, note 6.

⁴⁸ Institute of Medicine, *supra*, note 1.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ Karel et al., *supra*, note 6.

Direct care workers, peer support providers, and consumers and their families are playing increasingly vital roles in the MH/SU workforce. Training for these groups is less systematic and thus more difficult to analyze. (Institute of Medicine, 2012, p. 159)⁵²

Recruiting and/or preparing geriatric mental health providers is accompanied by additional barriers. Some of these barriers are addressed in the Institute of Medicine (2012)⁵³ report.

Across all health professions, relatively few opportunities exist for specialization in geriatric MH/SU. There is little support or mentorship available for those who do pursue specialization.

Financial incentives are not in place to encourage geriatric MH/SU providers to enter and stay in this field.

Professional training in geriatric MH/SU is inconsistent and not well documented because national standards and requirements in these areas are minimal and vague. MH/SU specialists have little required training in geriatrics; geriatric specialists have little required training in MH/SU; and most general providers do not have extensive requirements in either area. (Institute of Medicine, 2012, p. 8-9)⁵⁴

Mental health services are incredibly expensive, and the acceptance rates for all types of insurance have been significantly lower for psychiatrists than for physicians in other specialties.

... The percentage of psychiatrists who accepted Medicare in 2009-2010 was significantly lower than that for other physicians (54.8% [95% CI, 46.6%-62.7%] vs 86.1% [84.4%-87.7%]; $P < .001$) and had declined by 19.5% since 2005-2006. (Bishop et al., 2014, p. 176)⁵⁵

This decline in Medicare acceptance by psychiatrists has large implications for the state of the geriatric mental health system, specifically access to and quality of care.

Mental health services, and consequently the geriatric mental health system, have chronically been underfunded in the U.S.

Even when available, specialized mental health services have been underutilized by older adults. Community mental health services tend to underserve older adults, and thus most geriatric mental health care is received in primary and long-term care locations. However, there is also an unmet need for mental health services in these settings, including nursing homes. These unmet needs have serious cost implications.

⁵² Institute of Medicine, *supra*, note 1.

⁵³ *Ibid.*

⁵⁴ *Ibid.*

⁵⁵ Bishop, T. F., Press, M. J., Keyhani, S., & Pincus, H. A. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA psychiatry*, 71(2), 176-181.

The quality of the mental health services to which older adults do have access tends to be less than adequate. Mental health quality measurements in general are lacking.

The service delivery system for older adults is fragmented. Primary care, mental health specialty services, community-based services, aging network services, home health care, nursing homes, assisted living facilities, and family caregivers are all settings or sources of possible geriatric mental health services. There is no comprehensive policy, however, to coordinate or integrate all of these different settings of potential services. State mental health departments often times do not coordinate with state departments that handle aging issues. This lack of coordination leaves geriatric mental health issues too often unaddressed.

As with the deficiencies in the prevalence data previously discussed, utilization data for mental health services by older adults is also lacking. This prevents geriatric mental health providers, researchers, policy makers, and the system as a whole from being more informed and guided by empirical data.

Comprehensive information is not available about the proportion or number of adults with MH/SU conditions that use any of the kinds of MH/SU, and much less information is available about detection than about diagnosis, treatment, ongoing management and monitoring. (Institute of Medicine, 2012, p. 123)⁵⁶

Section 5. Current Mental Health Services for Older Adults

A variety of services are required to meet the nation's geriatric mental health needs. These services include prevention, screening, diagnosis, treatment, and monitoring.

Preventative options to sustain mental health throughout the aging process include eating nutritiously, limiting alcohol intake, keeping physically active, staying connected with social groups, engaging in mentally stimulating activities, maintaining healthy sleeping practices, and seeking proper medical attention when necessary. Madhusoodanan et al. (2010)⁵⁷ identifies various geriatric modifiable risk factors for several mental illnesses and possible preventative interventions. For example, some modifiable risk factors for depression in the elderly and their respective possible interventions include: physical illness and problem-solving therapy; social isolation and increasing social support and networks; bereavement/major loss events and psychotherapy; and stress and aerobic exercise.⁵⁸ Thus, modification of risk factors for geriatric mental illness is another preventative option to sustain mental health in older adults.

Lifelong learning is an example of an activity to preserve mental health throughout the aging process. Certain lifelong learning programs have national, state, and/or local centers. An example of a nationally recognized lifelong learning program is the Osher Lifelong Learning Institutes. Such centers can provide a variety of courses on everything from cognitive skills to life skills

⁵⁶ Institute of Medicine, *supra*, note 1.

⁵⁷ Madhusoodanan, S., Ibrahim, F. A., & Malik, A. (2010). Primary prevention in geriatric psychiatry. *Annals of clinical psychiatry*, 22(4), 249-261.

⁵⁸ *Ibid.*

training. One study by Fernández-Ballesteros et al. (2012)⁵⁹ even reports that lifelong learning university programs for older adults can improve memory and learning functioning and increase positive affect and affect balance.

There are many evidence-based geriatric mental health services including mental health outreach, integrated care, case management, family/caregiver support, and pharmacological and/or psychosocial treatments.

Pharmacological options have been shown to be especially effective in treating geriatric depression, symptoms of dementia, schizophrenia, and anxiety.⁶⁰ However, certain safety issues have been identified from geriatric use of pharmacological treatments, especially benzodiazepines. Psychosocial options, particularly cognitive-behavioral therapy (CBT) and problem-solving therapy for geriatric depression,^{61:62} behavioral and environmental modifications and behavioral problem-solving therapies for symptoms of dementia,^{63:64} and relaxation training and CBT for anxiety disorders,⁶⁵ have also been shown to be effective in treating geriatric mental illness.

The evidence base for psychological assessment, intervention, and consultation with older adults and relevant systems is growing and increasingly solid. (Karel et al., 2012, p. 192)⁶⁶

Throughout the past 50 years, the setting for mental health services has largely transitioned from psychiatric hospitals to community-based facilities. This movement is known as deinstitutionalization. Research has supported this transition, and empirical evidence shows that community-based mental health services (e.g., supported housing and employment programs, primary care medical services, community mental health centers, and Assertive Community Treatment (ACT)) are effective in managing mental illness. However, many professionals argue that as a result of lack of funding and increased fragmentation, numerous individuals have been left without access to adequate mental health care.

Scholars estimate that one-third of older adults living in the community need mental health care but less than 3% are seen in outpatient mental health clinics, psychiatric hospitals, general hospitals with psychiatric units, and VA medical centers combined.

⁵⁹ Fernández-Ballesteros, R., Molina, M. Á., Schettini, R., & del Rey, Á. L. (2012). Promoting active aging through university programs for older adults: An evaluation study. *GeroPsych: The Journal of Gerontopsychology and Geriatric Psychiatry*, 25(3), 145-154.

⁶⁰ Bartels, S. J., Dums, A. R., Oxman, T. E., Schneider, L. S., Areán, P. A., Alexopoulos, G. S., & Jeste, D. V. (2002). Evidence-based practices in geriatric mental health care. *Psychiatric services*, 53(11), 1419-1431.

⁶¹ Ibid.

⁶² Scogin, F., Welsh, D., Hanson, A., Stump, J., & Coates, A. (2005). Evidence-based psychotherapies for depression in older adults. *Clinical Psychology: Science and Practice*, 12(3), 222-237.

⁶³ Bartels et al, supra, note 60.

⁶⁴ Logsdon, R. G., McCurry, S. M., & Teri, L. (2007). Evidence-based psychological treatments for disruptive behaviors in individuals with dementia. *Psychology and aging*, 22(1), 28-36.

⁶⁵ Ayers, C. R., Sorrell, J. T., Thorp, S. R., & Wetherell, J. L. (2007). Evidence-based psychological treatments for late-life anxiety. *Psychology and Aging*, 22(1), 8-17.

⁶⁶ Karel et al., supra, note 6.

Traditional outpatient programs have not been responsive to the mental health needs of older people living in the community for several reasons, including the limited availability of mental health programs, the lack of staff knowledgeable about geriatric mental health care, the failure of older people and their family members to recognize the presence of mental health problems, the reluctance of older people to use services, and the many practical barriers to utilization of services, e.g. lack of transportation, impaired physical mobility. (Cohen and King-Kallimanis, 2011, p. 306)⁶⁷

Providing access to community-based mental health services better suited to older adults is critical. The integration of primary care and other mental health services is an especially important change for this demographic. Additionally, to overcome the barriers to utilization of services, such as lack of transportation and impaired physical mobility, home-based psychiatric services might provide superior options. Possibilities for such home-based programs include crisis response teams and mobile mental health teams, however more data is needed to evaluate the effectiveness of these programs for older adults.⁶⁸ Recent research suggests that ACT might be an effective option for managing older adults with SMI.⁶⁹

System-based interventions for geriatric mental health care have received increased attention. There are several evidence-based models of care that are effective for managing geriatric mental health issues. Examples of evidence-based models of care for older adults regarding depression in particular include Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), IMPACT (Improving Mood-Promoting Access to Collaborative Treatment), and PEARLS (Program to Encourage Active and Rewarding Lives for Seniors). Healthy IDEAS and IMPACT are both community-based programs and PEARLS is a home-based program. The Centers for Disease Control and Prevention and National Association of Chronic Disease Directors (2009)⁷⁰ provides extensive information on these three programs and their proven effectiveness.

Healthy IDEAS is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations through existing community-based case management services. Healthy IDEAS integrates depression awareness and management into existing case management services provided to older adults (such as those that offer assistance with home-based care). The program also seeks to improve the linkage between community aging service providers (for example, area agencies on aging) and health care professionals through appropriate referrals, better communication, and effective partnerships... Participants showed reductions in depression severity

⁶⁷ Cohen, D., & King-Kallimanis, B. L. (2011). A geriatric mobile crisis response team: A resilience-promoting program to meet the mental health needs of community-residing older people. In *Resilience in Aging* (pp. 305-315). Springer New York.

⁶⁸ Ibid.

⁶⁹ Stobbe, J., Wierdsma, A. I., Kok, R. M., Kroon, H., Roosenschoon, B. J., Depla, M., & Mulder, C. L. (2014). The effectiveness of assertive community treatment for elderly patients with severe mental illness: A randomized controlled trial. *BMC psychiatry*, *14*(1), 42.

⁷⁰ Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. (2009). *The state of mental health and aging in America issue brief 2: Addressing depression in older adults: Selected evidence-based programs*. Atlanta, GA: National Association of Chronic Disease Directors.

and self-reported pain, increased knowledge of how to get help for depression, increased physical activity levels, and knowledge of how to manage depressive symptoms.

IMPACT is a program for older adults who have major depression or dysthymic disorder. The intervention is a stepped, collaborative care approach in which a nurse, social worker, or psychologist works with the participants' regular primary care provider to develop a course of treatment... Patients receiving IMPACT care were twice as likely as usual care patients to experience a 50% or greater reduction in depression symptoms. IMPACT patients also experienced greater rates of depression treatment, greater satisfaction with their depression care, less functional impairment, and better quality of life. These benefits were sustained 12 months after IMPACT care ended. To date, over 50 peer-reviewed articles documenting the extensive evidence base for IMPACT, including evaluations of adaptations and implementations that took place after the conclusion of the original randomized controlled trial, have been published.

PEARLS is a brief, time-limited, and participant-driven program that teaches depression management techniques to older adults with depression. It is offered to people who are receiving home-based services from community services agencies. The program consists of in-home counseling sessions followed by a series of maintenance session contacts conducted over the telephone... Participants who received PEARLS intervention were three times more likely than those receiving usual care to significantly reduce their depressive symptoms (43% vs. 15%) or completely eliminate their depression (36% vs. 12%). Participants were more likely to report greater health-related quality of life improvements in functional and emotional well-beings, as well as reduced use of health care services, including hospitalizations, compared to those receiving usual care. (Centers for Disease Control and Prevention and National Association of Chronic Disease Directors, 2009, p. 4-9)⁷¹

PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial) is an example of an effective, community-based model of care implementing case management for reducing suicide ideation in older adults with depression.⁷² TRIAD (Training in Assessment of Depression) is an example of an effective model of training of home health nurses to assess depression and increase appropriate referral and care for patients.⁷³ The Institute of Medicine (2012)⁷⁴ also identifies HOPES (Helping Older Persons Experience Success) and PREVENT (Providing Resources Early to Vulnerable Elders Needing Treatment) as effective programs for helping older adults with SMI

⁷¹ Ibid.

⁷² Bruce, M. L., Ten Have, T. R., Reynolds III, C. F., Katz, I. I., Schulberg, H. C., Mulsant, B. H., ... & Alexopoulos, G. S. (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: A randomized controlled trial. *Jama*, 291(9), 1081-1091.

⁷³ Bruce, M. L., Brown, E. L., Raue, P. J., Mlodzianowski, A. E., Meyers, B. S., Leon, A. C., ... & Nassisi, P. (2007). A randomized trial of depression assessment intervention in home health care. *Journal of the American Geriatrics Society*, 55(11), 1793-1800.

⁷⁴ Institute of Medicine, *supra*, note 1.

residing in the community and older adults with Alzheimer's disease and their caregivers, respectively.

Despite the existence of these various models of care for geriatric mental health issues, implementation of these programs and access to care has remained limited.

Research on strategies to overcome existing barriers to their use, and to extend their reach to new populations and health care settings, is necessary, but limited by funding for such research and models of care. Implementation is limited by the need for significant education and training of primary care providers and health systems, caregivers, families, and administrators of long-term care settings in the importance of identifying and fully treating identified mental health disorders such as depression, as well as the need to develop more effective models for the use of limited specialty mental health resources. (Carlson and Snowden, 2014, p. 659)⁷⁵

The integration of primary care and mental health services is necessary for a more effective geriatric mental health system. IMPACT is an example of an evidence-based collaborative care model for mental health services for managing older adults with depression. Furthermore:

On the level of an entire health care system, the Veterans Affairs Health Care System (VA) offers an aspirational model for integrated geriatric care. The VA system provides interdisciplinary geriatric care in home-based, outpatient, and extended care settings and integrated mental health care in primary settings for veterans of all ages. The VA has integrated psychologists into treatment teams in primary care, home-based primary care, community living centers (skilled nursing, rehabilitation, and palliative care), and specialized palliative care, as well as in traditional mental health treatment settings. (Karel et al., 2012, p. 190)⁷⁶

Many older adults also require mental health services in long-term care settings, primarily nursing homes. Pharmacological and psychosocial interventions are usually effective treatment options for such individuals. Yet, evidence-based intervention studies in this population are lacking.⁷⁷ The quality of mental health services in nursing homes tends to be poor.

Although future research is necessary, the extant literature suggests that persons with mental illness are frequently admitted to nursing homes and their care is often of poor quality and related to a series of resident and facility factors. (Grabowski et al., 2010, p. 627)⁷⁸

Current federal and state regulations do not require the availability of specialized mental health personnel or that nursing home staff demonstrate minimum

⁷⁵ Carlson, W. L., & Snowden, M. (2014). Community treatment of older adults: Principles and evidence supporting mental health service interventions. *Clinics in Geriatric Medicine*, 30(3), 655-661.

⁷⁶ Karel et al., supra, note 6.

⁷⁷ Carlson and Snowden, supra, note 75.

⁷⁸ Grabowski, D. C., Aschbrenner, K. A., Rome, V. F., & Bartels, S. J. (2010). Review: quality of mental health care for nursing home residents: a literature review. *Medical Care Research and Review*, 67(6), 627-656.

competency in the care of geriatric mental health issues. Survey statistics indicate that only 25% of nursing homes have mental health providers on staff, and only 24% use on-call providers. (Carlson and Snowden, 2014, p. 658)⁷⁹

It is also of importance to note the type of mental health services that older adults prefer. Because of coexisting physical conditions, older adults are significantly more likely to seek and accept services in primary care versus specialty mental health care settings for the sake of convenience. Also, some research shows that older adults favor psychotherapy to psychiatric medications. A study by Koh et al. (2010)⁸⁰ sought public feedback on mental health services for the elderly.

The effort resulted in 800 responses that identified three primary issues: problems in accessing care, inadequate detection of mental health conditions by general practitioners, and a need for more psychotherapy services. (Koh et al., 2010, p. 1146)⁸¹

There appeared to be a trend toward increased interest in psychotherapy by the current cohort of geriatric patients, compared with previous generations, and it seems likely that this will continue with the aging of the baby boomers. (Koh et al., 2010, p. 1148)

Overall, the effective geriatric mental health services for individuals with dementia and Alzheimer's disease in particular are more limited. There is currently no pharmacological treatment to cure Alzheimer's disease, however:

Despite the lack of disease-modifying therapies, studies have shown consistently that active medical management of AD and other dementias can improve quality of life through all stages of the disease for individuals with dementia and their caregivers. Active management includes (1) appropriate use of available treatment options; (2) effective management of coexisting conditions; (3) coordination of care among physicians, other health care professionals, and lay caregivers; (4) participation in activities and/or adult daycare programs; and (5) taking part in support groups and supportive services. (Alzheimer's Association, 2013, p. 214)⁸²

Various sources support geriatric mental health services through providing funding/financial aid.

Medicaid also administers two programs that serve older adults with MH/SU conditions: Home- and community-based waivers for individuals who otherwise require care in a nursing home or other institutional setting (about 30 percent of all long-term care Medicaid spending) and The "Money Follows the Person" rebalancing demonstration programs, which helps state Medicaid programs support the use of home- and community-based services in lieu of nursing homes or other

⁷⁹ Carlson and Snowden, *supra*, note 75.

⁸⁰ Koh, S., Blank, K., Cohen, C., Cohen, G., Faison, W., Kennedy, G., ... & Streim, J. (2010). Public's view of mental health services for the elderly: Responses to dear Abby. *Psychiatric Services*, 61(11), 1146-1149.

⁸¹ *Ibid.*

⁸² Alzheimer's Association, *supra*, note 18.

institutional services (including for older adults with SMI who are transitioning out of institutions in the community). (Institute of Medicine, 2012, p. 30-31)⁸³

A variety of funding sources support older adult behavioral health services, including Titles III-B, III-D, and III-E of the Older Americans Act (OAA); Medicaid and Medicare; Affordable Care Act (ACA) initiatives; and other flexible and targeted funding streams. (Substance Abuse and Mental Health Services Administration and Administration on Aging, 2013, p. 1)⁸⁴

Section 6. Cost-Effectiveness of Mental Health Care for Older Adults

The costs of mental illness in older adults are enormous and are predicted to continue to increase as the number of older adults grows. Preventative interventions to maintain mental health throughout the aging process are abundant. There is some research to indicate the potential cost-effectiveness of directing preventative efforts toward older adults at high-risk for geriatric mental illness.^{85;86;87} There is also evidence to indicate the potential cost-effectiveness of early diagnosis/interventions for geriatric mental illness.⁸⁸ More research, however, is needed on these topics before generalizations can be made.

Pharmacological and psychosocial interventions have proven effective in treating geriatric mental illness.⁸⁹ These treatments can improve quality of life, decrease demands placed on caregivers and health services (especially on expensive long-term care services), and decrease morbidity. Generally, treatment of geriatric mental illness is cost-effective when compared with the costs of untreated disease.^{90;91}

⁸³ Institute of Medicine, *supra*, note 1.

⁸⁴ Substance Abuse and Mental Health Services Administration and Administration on Aging. (2013). *Older Americans behavioral health: Issues brief 9: Financing and sustaining older adult behavioral health and supportive services*. Substance Abuse and Mental Health Services Administration and Administration on Aging.

⁸⁵ Smit, F., Ederveen, A., Cuijpers, P., Deeg, D., & Beekman, A. (2006). Opportunities for cost-effective prevention of late-life depression: An epidemiological approach. *Archives of General Psychiatry*, 63(3), 290-296.

⁸⁶ Smits, F., Smits, N., Schoevers, R., Deeg, D., Beekman, A., & Cuijpers, P. (2008). An epidemiological approach to depression prevention in old age. *The American Journal of Geriatric Psychiatry*, 16(6), 444-453.

⁸⁷ van't Veer-Tazelaar, P., Smit, F., van Hout, H., van Oppen, P., van der Horst, H., Beekman, A., & van Marwijk, H. (2010). Cost-effectiveness of a stepped care intervention to prevent depression and anxiety in late life: Randomised trial. *The British Journal of Psychiatry*, 196(4), 319-325.

⁸⁸ Banerjee, S., & Wittenberg, R. (2009). Clinical and cost effectiveness of services for early diagnosis and intervention in dementia. *International journal of geriatric psychiatry*, 24(7), 748-754.

⁸⁹ Bartels et al., *supra*, note 60.

⁹⁰ Evans, M., & Mottram, P. (2000). Diagnosis of depression in elderly patients. *Advances in psychiatric treatment*, 6(1), 49-56.

⁹¹ National Committee to Preserve Social Security and Medicare, the SPRY Foundation, and the American Association for Geriatric Psychiatry. (2001). *Mental health & aging: The challenge confronting America's families and senior citizens*. Retrieved from: <http://www.spry.org/pdf/MentalHealth.pdf>

The settings and models in which geriatric mental health treatments are disseminated also deserve analysis. A study by Klug et al. (2010)⁹² found that home treatment is cost-effective in serving older adults with depression.

Participants in the geriatric home treatment group also had fewer admissions to nursing homes and spent fewer days in psychiatric in-patient care. Because of the successful prevention of admissions to psychiatric in-patient care and nursing homes, geriatric home treatment was associated with substantially lower care costs. As compared with conventional psychiatric out-patient care, geriatric home treatment can be seen as a very effective and cost-effective form of treatment. (Klug et al., 2010, p. 466)⁹³

Integrated care also provides opportunities for cost-effectiveness, especially in the geriatric mental health care system.

Integrating behavioral health services in medical settings can lead to better outcomes and cost savings. (Karel et al., 2012, p. 190)⁹⁴

Research on a specific model of integrated care, IMPACT, has confirmed the cost-effectiveness of certain collaborative care interventions for geriatric mental illness.⁹⁵

IMPACT participants had lower mean total healthcare costs (\$29 422; 95% confidence interval, \$26 479-\$32 365) than usual care patients (\$32 785; 95% confidence interval, \$27 648-\$37 921) during 4 years. Results of a bootstrap analysis suggested an 87% probability that the IMPACT program was associated with lower healthcare costs than usual care. (Unützer et al., 2008, p. 95)⁹⁶

A study by Tadros et al. (2013)⁹⁷ found that integrated models of care in the hospital can also be cost-effective. In this study, the RAID (Rapid Assessment, Interface and Discharge) model was evaluated to determine if its implementation would improve access to psychiatric services and reduce associated costs in acute hospitals. Tadros et al. (2013)⁹⁸ reports:

In an acute hospital with 600 beds, the total savings in bed days through reducing length of stay and readmissions was 43-64 beds per day. The elderly care wards provided the majority of bed savings.

⁹² Klug, G., Hermann, G., Fuchs-Nieder, B., Panzer, M., Haider-Stipacek, A., Zapotoczky, H. G., & Priebe, S. (2010). Effectiveness of home treatment for elderly people with depression: Randomised controlled trial. *The British Journal of Psychiatry*, 197(6), 463-467.

⁹³ Ibid.

⁹⁴ Karel et al., supra, note 6.

⁹⁵ Unützer, J., Katon, W. J., Fan, M. Y., Schoenbaum, M. C., Lin, E. H., Della Penna, R. D., & Powers, D. (2008). Long-term cost effects of collaborative care for late-life depression. *The American journal of managed care*, 14(2), 95-100.

⁹⁶ Ibid.

⁹⁷ Tadros, G., Salama, R. A., Kingston, P., Mustafa, N., Johnson, E., Pannell, R., & Hashmi, M. (2013). Impact of an integrated rapid response psychiatric liaison team on quality improvement and cost savings: the Birmingham RAID model. *The Psychiatrist*, 37(1), 4-10.

⁹⁸ Ibid.

The development of a rapid response, age-inclusive, comprehensive psychiatric team integrated in an acute hospital can lead to significant savings in health service provision. (Tadros et al., 2013, p. 4)⁹⁹

Eventually, greater comparative cost-effectiveness analysis on the different geriatric mental health services will also be beneficial. For example, a recent study by Kaplan and Zhang (2012)¹⁰⁰ reports that in the U.S. elderly Medicare population:

... Sertraline is the most cost-effective drug to treat depression. Substantial savings to Medicare could be realized by using more cost-effective antidepressants such as sertraline. (Kaplan and Zhang, 2012, p. 171)¹⁰¹

Overall, more cost-effectiveness research on geriatric mental health care, especially on integrated care models, is needed.

If the nation is to confront the growing burden of Medicare costs, it must develop ways to maximize the productive capacity of the geriatric MH/SU workforce. (Institute of Medicine, 2012, p. 23)¹⁰²

Section 7. Recent Changes in Geriatric Mental Health Policy

One of the recent changes in geriatric mental health policy is parity for coverage of mental health/substance use services with physical health services.

In 2008, two landmark bills mandating parity in mental health insurance coverage of MH/SU services became law: (1) the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275) and (2) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343).

MIPPA equalizes the outpatient Medicare coinsurance rates, thus creating ‘parity’ in the coverage of mental health and physical health care. The reduction in the coinsurance rate from 50 to 20 percent is being phased in over a 5-year period starting in 2010. (Institute of Medicine, 2012, p. 24)¹⁰³

The Mental Health Parity and Addiction Equity Act:

⁹⁹ Ibid.

¹⁰⁰ Kaplan, C., & Zhang, Y. (2012). Assessing the comparative-effectiveness of antidepressants commonly prescribed for depression in the US Medicare population. *The journal of mental health policy and economics*, 15(4), 171-178.

¹⁰¹ Ibid.

¹⁰² Institute of Medicine, supra, note 1.

¹⁰³ Ibid.

... Mandated parity in the coverage of physical and MH/SU conditions by employer-sponsored group health plans with more than 50 insured employees. (Institute of Medicine, 2012, p. 24)¹⁰⁴

The Affordable Care Act (ACA) allows for the overall expansion of coverage to numerous individuals and the expansion of the Mental Health Parity Act discussed above.

The Patient Protection and Affordable Care Act expands coverage to an additional 32 million individuals by 2019. The act also requires the expansion of Medicaid coverage to those with incomes 133% of the poverty level, inclusion of mental health care and addiction treatment on the list of essential benefits that must be covered in new plans, and expansion of the Mental Health Parity Act of 2008 to health insurance plans offered to small business and individuals. (Karel et al., 2012, p. 189)¹⁰⁵

The ACA also affords other opportunities for advances in the geriatric mental health system. The ACA improves coverage of Medicare Part D, which includes the coverage of psychiatric medications. The ACA emphasizes preventative interventions, allowing certain screenings (e.g., depression screenings) and other preventative interventions to be covered. Furthermore, the ACA supports care coordination. This integrated approach to health care is especially important for the geriatric population.

... The ACA permits Medicaid enrollees with at least two chronic conditions or at least one serious mental illness to designate a provider (e.g., a community mental health center, hospital, or other community setting) as a health care home, qualifying for 90% federal funding as of January 2011. Health care homes are designated to coordinate a full array of services for each individual, drawing on a team-based approach. Similarly, the act calls for new grants to collocate primary and specialty care services in community-based mental and behavioral health settings. (Karel et al., 2012, p. 189)¹⁰⁶

The Elder Justice Act was also enacted as a part of the ACA. This act provides federal support, according to the American Psychological Association (APA), to prevent, detect, treat, understand, intervene in and, where appropriate, prosecute elder abuse, neglect, and exploitation. This attention toward preventing and eliminating elder abuse is relevant to geriatric mental health because elder abuse can be traumatic and elicit severe emotional and mental health problems.

Policy surrounding mental health for older adults has also recently focused on workforce development, funding, research, coalition building, and integrated service systems. The urgency surrounding the management of mental health issues in older adults, especially as this population continues to grow, has been recognized by the federal government.

¹⁰⁴ Ibid.

¹⁰⁵ Karel et al., *supra*, note 6.

¹⁰⁶ Ibid.

The following year, because of similar concerns about geriatric mental health and substance use (MH/SU) needs, Congress mandated that the IOM undertake a complementary study focusing on the geriatric MH/SU workforce needs of the nation. Thus, in response to the congressional mandate, the IOM entered into a contract with the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Mental Health and Human Services (HHS) in September 2010. The IOM Committee on the Mental Health Workforce for Geriatric Populations was appointed in early 2011 to carry out the charge. (Institute of Medicine, 2012, p. 18)¹⁰⁷

The findings from this extensive study are referenced frequently throughout this report. Overall, the Institute of Medicine (2012)¹⁰⁸ report has identified a critical deficiency in the geriatric mental health workforce and has established national recommendations for change accordingly.

There has been much pressure to control funding at the national and state levels, often causing budget cutbacks for mental health services. Several states are currently attempting to improve their mental health budgets.¹⁰⁹ Generally, however, these budgets remain critically low.

The steady rise in prevalence of Alzheimer's disease and other dementias has also resulted in recent mental health policy change. In 2011, the National Alzheimer's Project Act (NAPA) was enacted to create a plan to address this major public health concern. The CDC has developed *The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018* to help address this prominent issue.

Section 8. Current Geriatric Mental Health Services and Policy in Florida

As with national data on the exact prevalence of mental illness in older adults, state data on the prevalence of mental illness in older Floridians remains elusive, but the general consensus is that mental illness/conditions are prominent in this population. The CDC's Behavioral Risk Factor Surveillance System (BRFSS) measures the mental health parameter of frequent mental distress, defined as having had 14 or more mentally unhealthy days in the previous month. In 2010, 6.9% of persons age 65 or older reported frequent mental distress; in Florida during this same year, 7.4% of persons age 65 or older reported frequent mental distress.¹¹⁰ In 2006, the BRFSS also measured current depression. In 2006, Florida was one of the states in which the percentage of adults aged 50 or older who had current depression ranged from 5.42-6.66%.¹¹¹ The CDC's Healthy Aging Data Portfolio further reveals that in 2006, for adults aged 65 and older, 5.0% reported current depression; in Florida during this same year, 4.1% of adults aged 65 and older reported current depression.¹¹² The Florida Department of Elder Affairs records county and state profiles for the demographics of older Floridians. According to these demographics, in 2013, the probable

¹⁰⁷ Institute of Medicine, *supra*, note 1.

¹⁰⁸ *Ibid.*

¹⁰⁹ Substance Abuse and Mental Health Services Administration & Administration on Aging, *supra*, note 84.

¹¹⁰ Centers for Disease Control and Prevention. (2013). *The state of aging and health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services.

¹¹¹ Centers for Disease Control and Prevention & National Association of Chronic Disease Directors, *supra*, note 12.

¹¹² Healthy Aging Data Portfolio (Online). Centers for Disease Control and Prevention (producer). Available at: http://nccd.cdc.gov/DPH_Aging/default.aspx (accessed July 16, 2014).

Alzheimer's cases (60+) was 424,869, and the disability status (60+) with one type of disability, specifically a cognitive one, was 378,217.¹¹³ State suicide prevalence rates are also available. According to the CDC's Web-based Injury Statistics Query and Reporting System (WISQARS™), the 2004-2010 death rate per 100,000 for fatal injuries due to suicide in the U.S. for the high-risk group of men age 65 and older was 28.92; this rate for men age 65 and older in Florida was 33.52.¹¹⁴ Extensive updates are needed on the state of geriatric mental health in Florida.

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) provides Uniform Reporting System (URS) Output Tables, via the National Outcome Measures (NOMS), which show statistics on the people served by state mental health services. In Florida in 2012, 319,190 total clients were served by the SMHA system; there was a 16.75 total utilization rate per 1,000 population, whereas the U.S. rate was 22.67.¹¹⁵ In Florida, 11,070 of those served were 65 and over. The 65 to 74 age group had a 4.7 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 9.0; the 75 and over age group had a 1.7 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 7.0.

In Florida, the Department of Children and Families (DCF) is responsible for state mental health services and the Department of Elder Affairs (DOEA) is responsible for administering state services and programs to benefit Florida's older adults. Although these departments are separate entities, collaboration ensures that geriatric mental health issues are not overlooked. Throughout the past decade, the DCF and the DOEA have collaborated on various programs, especially those centered on prevention and screening services, to provide better mental health and substance use disorder care for older adults. However, more extensive collaborative efforts are needed.

The DCF handles the assessment and implementation of mental services for adults of all ages. These services include adult mental health treatment, adult mental health prevention, adult mental health crisis programs, and Pre-Admission Screening and Resident Review ([PASRR] an evaluation process to assess for individuals with suspected SMI in the nursing home system). The DOEA has some programs and services that address geriatric mental health including the Alzheimer's Disease Initiative and the Health and Wellness program.

The DOEA has developed an intricate system for evaluating the needs, and the utilization of services, of Florida's older adult population. In 2010, the Florida Needs Assessment Survey was distributed through the DOEA. The CDC has praised this assessment for providing an example of how other states can examine their older adult populations to better serve their needs. Florida Department of Elder Affairs (2013),¹¹⁶ reports that:

¹¹³ Florida Department of Elder Affairs. (2013). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹¹⁴ Web-based Injury Statistics and Query Reporting System (WISQARS) (Online), *supra*, note 24.

¹¹⁵ Center for Mental Health Services. (2013). *2012 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹¹⁶ Florida Department of Elder Affairs. (2013). *Assessing the needs of elder Floridians, 2011*. Tallahassee, FL: Bureau of Planning and Evaluation, Department of Elder Affairs.

Although highly successful when treated, 11% of statewide elders surveyed had to go without treatment for emotional or mental health problems... (Florida Department of Elder Affairs, 2013, p. 22)¹¹⁷

Continued development of the study of state geriatric mental health needs and subsequent improvements are necessary.

Examples of some of the current geriatric mental health services available in Florida include pharmacological treatments, psychosocial treatments such as psychotherapy, medication management, and hospitalization. Relevant DOEA-administered programs include the Alzheimer's Disease Initiative (ADI), Community Care for the Elderly (CCE), Comprehensive Assessment and Review for Long-Term Care Services (CARES), Health and Wellness, Aging and Disability Resource Centers, and Healthy IDEAS. The following information on these programs is taken directly from the DOEA's website:¹¹⁸

Florida's Alzheimer's Disease Initiative (ADI) provides services to meet the changing needs of individuals and families affected by Alzheimer's disease and similar memory disorders... The program includes four components: supportive services including counseling, consumable medical supplies and respite for caregiving relief; memory disorder clinics to provide diagnosis, research, treatment, and referral; model day care programs to test new care alternatives; and a research database and brain bank to support research.

The Community Care for the Elderly (CCE) Program provides community-based services organized in a continuum of care to help functionally impaired older people live in the least restrictive yet most cost-effective environment suitable to their needs... Eligible clients may receive a wide range of goods and services, including: adult day care, adult day health care, case management, case aide, chore, companionship, consumable medical supplies, counseling, escort, emergency alert response, emergency home repair, home-delivered meals, home health aide, homemaker, home nursing, information and referral, legal assistance, material aid, medical therapeutic services, personal care, respite, shopping assistance, transportation, and other community-based services.

Comprehensive Assessment and Review for Long-Term Care Services (CARES) is Florida's federally mandated pre-admission screening program for nursing home applicants... The program emphasizes approaches that make it possible for individuals to remain in their homes through home-based services, or in alternative community placements such as assisted living facilities... The services or activities in this program include: medical eligibility for the Medicaid Institutional Care Program (ICP); medical eligibility for several Medicaid waivers that provide community services; medical assessment for all mentally ill clients for ICP; medical assessment for all developmentally disabled clients for ICP; medical assessment for

¹¹⁷ Ibid.

¹¹⁸ Florida Department of Elder Affairs. *DOEA programs and services*. Retrieved from: <http://elderaffairs.state.fl.us/doea/programs.php>

residents in nursing facilities entering court-ordered receivership; and medical utilization review of Medicaid nursing home residents for continuing eligibility.

The Department encourages seniors to develop and maintain healthy lifestyles to live a better, fuller life. Disease prevention and health promotion services are offered to Florida seniors through the Older Americans Act, Title III D program. These services are offered through various evidence-based interventions so seniors can maintain health and functional independence and lead healthy and independent lives. (Florida Department of Elder Affairs)¹¹⁹

The DCF has recently released the *Substance Abuse and Mental Health Services Plan: 2015 Annual Plan Update*.¹²⁰ This update outlines the direction for Florida's mental health system for 2014-2016 as well as describes relevant bills from the 2014 legislative session. Although the Florida Legislature passed a couple of bills related to substance abuse and mental health services, recent bills have not addressed geriatric mental health specifically. However, the following bill relates to mental health services in general:

HB 5003 – Implementing Bill: Section 10 provides that, notwithstanding any other law, behavioral health managing entities may not conduct provider network procurements during the 2014-2015 fiscal year. (Florida Department of Children and Families, 2015, p. 6)¹²¹

The DCF (2015)¹²² annual plan update also details the provisos from the 2014 legislative session. Again, recent provisos have not addressed geriatric mental health specifically, however the following provisos related to adult mental health services in general:

Community Action Teams (CATs): Specific Appropriation 349 allocates \$12,000,000 to continue funding ten (10) existing CAT Teams and implement six (6) new CAT Teams. These programs provide intensive, community-based services to families with children ages 11 to 21 with a mental health diagnosis or co-occurring substance abuse diagnosis who are considered high risk for out-of-home care.

Mental Health Transitional Beds: Specific Appropriation 351 allocates \$3,000,000 to three community mental health treatment providers to transition eligible individuals in state mental health treatment facilities to community-type settings as an alternative to more costly institutional placement. (Florida Department of Children and Families, 2015, p. 6)¹²³

¹¹⁹ Ibid.

¹²⁰ Florida Department of Children and Families. (2015). *2015 Substance abuse and mental health annual plan update: Compliance with annual reporting requirements per Section 394.75, Florida Statutes*. Tallahassee, FL: Office of Substance Abuse and Mental Health, Department of Children and Families.

¹²¹ Ibid.

¹²² Ibid.

¹²³ Ibid.

The following table¹²⁴ displays the Fiscal Year 2014-2015 Approved Operating Budget for Mental Health Services in Florida:

Mental Health Services							
Regions	Adult Community Mental Health	Children's Community Mental Health	Executive Leadership and Support Services	Civil Commitment Program	Forensic Commitment Program	Sexual Predator Program	Total
Headquarters	\$11,872,587	\$23,969,761	\$5,722,536	\$40,630,100	\$54,995,927	\$30,174,259	\$167,365,170
Northwest	\$27,963,532	\$6,314,573	\$464,318	\$0	\$0	\$0	\$34,742,423
Northeast	\$43,161,703	\$11,657,296	\$1,328,862	\$0	\$0	\$0	\$56,147,861
Suncoast	\$96,514,259	\$20,656,072	\$441,575	\$0	\$0	\$0	\$117,611,906
Central	\$31,209,072	\$11,932,853	\$335,117	\$0	\$0	\$0	\$43,477,042
Southeast	\$50,205,612	\$13,581,584	\$490,123	\$0	\$0	\$0	\$64,277,319
Southern	\$37,105,645	\$13,004,620	\$524,780	\$0	\$0	\$0	\$50,635,045
West Florida Community Care Center	\$0	\$0	\$0	\$5,823,881	\$0	\$0	\$5,823,881
Florida State Hospital	\$6,130,215	\$0	\$0	\$56,379,966	\$57,929,532	\$0	\$120,439,713
Northeast Florida State Hospital	\$0	\$0	\$0	\$66,341,499	\$0	\$0	\$66,341,499
North Florida Evaluation and Treatment Center	\$0	\$0	\$0	\$0	\$22,936,076	\$0	\$22,936,076
Control	\$980,928	\$693,882	\$0	\$0	\$129,709	\$0	\$1,804,519
Reserve	\$0	\$0	\$83,791	\$347,430	\$247,951	\$27,463	\$706,635
Unfunded Budget	\$9,570	\$3,155,675	\$266,803	\$0	\$0	\$0	\$3,432,048
Total	\$305,153,123	\$104,966,316	\$9,657,905	\$169,522,876	\$136,239,195	\$30,201,722	\$755,741,137

The Substance Abuse and Mental Health (SAMH) Program has identified initiatives to meet several established priorities for services and funding over the next five years.¹²⁵ Some of these relevant initiatives include the following:

- Use the LBR process to seek funds to assist over 130 persons in the civil State Mental Health Treatment Facilities who have been determined ready for community placement for 60 days or longer to be successfully reintegrated back into the community with appropriate treatment and necessary services.
- Provide a system of care that supports and promotes competitive employment opportunities for adults with behavioral health needs.
- Continue to implement the use of National Outcome Measures (NOMs), evidence based practices and quality indicators as the standard for system performance measurement and accountability.
- Develop statewide and local community service frameworks that promote a “no wrong door” approach to care for individuals and families affected by co-occurring substance use and mental disorders, cross-training substance abuse

¹²⁴ Ibid.

¹²⁵ Florida Department of Children and Families. (2013). *Substance abuse and mental health services plan: 2014-2016*. Tallahassee, FL: Department of Children and Families.

and mental health professionals, and protocols/policies that are welcoming and engaging for these individuals/families.

- Advance a system of care that sustains stable housing for adults and children with behavioral health disorders.
- Increase the diversion of people with substance dependence and/or mental health illnesses who become involved with the criminal justice system through expanding cost-effective community-based treatment alternatives to incarceration and forensic hospitalization.
- Continue to implement Managing Entity contracts throughout the state to promote a more efficient, locally controlled, responsive system of care. (Florida Department of Children and Families, 2013, p. 35-37)¹²⁶

The DOEA recently released the *2013 NAPIS Report*¹²⁷ detailing the utilization and expenditure profiles of various geriatric services/programs. The following table summarizes the information relevant to geriatric mental health services for Fiscal Year 2013:¹²⁸

Service Name	Service Unit Name	Mission/Purpose Category	OAA Service Expenditure Amount	Total Expenditure Amount	Estimated Unduplicated Persons Served	Estimated Service Units
Community Mental Health	VISIT	B	\$0.00	\$59,187.00	18	839.00
Counseling	HRS	B	\$3,381.00	\$191,006.00	324	3,433.00
Counseling (Gerontological) - Group	HRS	B	\$67,622.64	\$73,135.64	16	1,695.50
Counseling (Gerontological) - Individual	HRS	B	\$430,738.20	\$494,966.51	3,448	13,069.75
Counseling (Gerontological) – Vendor Payment	HRS	B	\$0.00	\$3,864.20	3	56.00
Counseling (Mental Health Counseling/Screening)	HRS	B	\$103,738.01	\$174,729.45	101	2,710.50
Gerontological Counseling	HRS	B	\$78,377.00	\$164,070.00	341	1,681.50
Mental Health Screening	HRS	B	\$47,985.00	\$72,293.00	95	1,047.50

The DOEA has also released the figures for the approved operating budget for 2014-2015. The resource allocation methodologies for the Alzheimer’s Respite and Projects program and the Community Care for the Elderly program, both of which offer geriatric mental health services, are detailed. According to the report:

The 2009 Legislature combined the Respite category 100250 and the Projects category 100096 into one new category titled: Alzheimer’s Disease Respite and Projects. These services are separated by an OCA... For SFY 09-10 \$337,290 in

¹²⁶ Ibid.

¹²⁷ Florida Department of Elder Affairs. (2014). *The state of Florida: 2013 NAPIS report*. Tallahassee, FL: Planning and Evaluation Bureau, Department of Elder Affairs.

¹²⁸ Ibid.

respite funding was reduced by the Legislature and Alzheimer's Projects was reduced by \$288,771. During fiscal year 08-09, the Legislature also reduced these programs mid year by 4% totaling \$516,949. These reductions were allocated across the board. FY 2011-2012 a total of \$250,000 was reduced due to an Alzheimer's Project going out of business and an additional \$949,730 was appropriated. (Florida Department of Elder Affairs, p. 1)¹²⁹

Furthermore, for the Community Care for the Elderly program:

The 2009 Legislature reduced this category by a total of \$1,092,842. The CCE Administration line was held harmless from reduction. The reduction was allocated as follows: CCE Services - \$1,041,516; ARC - \$40,972, CSS - \$10,354, HCE - \$415,966. For 2010-2011, there were no reductions to CCE, HCE or ARC. For 2011-2012, there were no reductions to CCE, HCE or ARC. (Florida Department of Elder Affairs, p. 1)¹³⁰

The critical need for more attention to geriatric mental health has been addressed in both the DOEA's *State Plan on Aging 2013-2016*¹³¹ and the DOEA's *Long-Range Program Plan Fiscal Years 2015-16 through 2019-20*.¹³²

To focus the Department's efforts to serve Florida's aging population, the following goals are established in the State Plan:

Goal 1: Information and Access – Enable older people, individuals with disabilities, their families, and other consumers to choose and easily access options for existing mental and physical health, and long-term and end-of-life care

Goal 2: Provide medical and home and community-based services to enable individuals to maintain a high quality of life for as long as possible, including supports for family caregivers

Goal 3: Health and Wellness – Empower older people and their caregivers to live active, healthy lives to improve their mental, behavioral, and physical health status

Goal 4: Ensure the legal rights of older people are protected and prevent their abuse, neglect, and exploitation

Goal 5: Promote planning and collaboration at the community level that recognize the benefits and needs of its aging population

¹²⁹ Florida Department of Elder Affairs. *Approved operating budget 2014-2015*. Tallahassee, FL: Department of Elder Affairs.

¹³⁰ Ibid.

¹³¹ Florida Department of Elder Affairs. (2012). *State plan on aging 2013-2016*. Tallahassee, FL: Bureau of Planning and Evaluation, Department of Elder Affairs.

¹³² Florida Department of Elder Affairs. (2014). *Long-range program plan fiscal years 2015-16 through 2019-20*. Tallahassee, FL: Office of Strategic Initiatives, Department of Elder Affairs.

Goal 6: Maintain effective and responsive management (Florida Department of Elder Affairs, 2012, p. 4)¹³³

The *State Plan on Aging 2013-2016*¹³⁴ report recognizes that collaborative care models for geriatric mental health can provide increased options for care and long-term costs savings and that there is a shortage of state geriatric mental health professionals. Continued efforts toward integrated care is discussed as a priority. In this report, the importance of training professionals and caregivers on the management of symptoms of dementia and the improvement of Alzheimer's disease and related dementia identification and treatment is likewise discussed. The comprehensive client assessment instrument has also been updated:

The new assessment instrument will incorporate questions and scoring from validated instruments on depression, dementia, and mental status. Specifically, the validated instruments include:

- PHQ-9, a brief depression survey used for self-reporting symptoms of depression;
- AD8, an eight-item informant interview to differentiate aging and dementia to capture caregiver insight into client memory loss; and
- BIMS (Brief Interview for Mental Status), which tests memory and orientation to time.

By collecting more information on problem areas, the revised assessment is designed to improve the accuracy of care planning, and using the same instruments as others, such as nursing homes and mental health clinics, should result in more appropriate referrals. (Florida Department of Elder Affairs, 2012, p. 28)¹³⁵

This report also details general strategies to meet the goals previously mentioned. The *Long-Range Program Plan Fiscal Years 2015-16 through 2019-20*¹³⁶ report reiterates these goals, while also listing relevant task forces and studies in progress. The work groups/task forces important to geriatric mental health include:

Alzheimer's Disease Advisory Committee, s. 430.501, F.S.: The committee, composed of 10 members selected by the Governor, advises the Department of Elder Affairs in the performance of its duties. All members must be residents of the state. The committee advises the Department regarding legislative, programmatic, and administrative matters that relate to individuals with Alzheimer's disease and their caregivers.

¹³³ Florida Department of Elder Affairs, *supra*, note 131.

¹³⁴ *Ibid.*

¹³⁵ *Ibid.*

¹³⁶ Florida Department of Elder Affairs, *supra*, note 132.

Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Review Committee: Reviews and determines successors for expansion and implementation grants at the request of the Secretary of the Department of Children and Families.

Governor's Mental Health Transformation – Recovery and Resiliency Workgroup: Florida's Transformation Working Group: Florida's Transformation Working Group has been charged with providing the leadership to make this vision a reality. State agency partners include the following: Agency for Health Care Administration, Department of Education, Department of Corrections, Department of Elder Affairs, and Department of Juvenile Justice.

Governor's Office of Drug Control Suicide Prevention Coordinating Council: The Governor's Office is leading an integrated and long-term approach to lowering the state's current suicide rate. The Suicide Prevention Coordinating Council serves in an advisory role to the Statewide Office of Suicide Prevention, which is charged with developing and implementing a statewide plan to decrease the suicide rate in the state.

National Association of PASRR Professionals (NAPP): NAPP is a national organization of professionals who collaborate to improve the quality of long-term care for individuals with mental illness, developmental disabilities, and related conditions. DOEA is a founding member.

State Mental Health Planning Council: Oversees the U.S. Substance Abuse and Mental Health Services Administration application for block grant funding for mental health services in Florida and the service delivery by contractors. (Florida Department of Elder Affairs, 2014, p. 25-31)¹³⁷

Subsequent reports from these work groups/task forces will be important to inform policy and improve Florida's geriatric mental health system.

Overall, follow-up data will reveal if the state plan to address geriatric mental health is effective and provides greater access to quality mental health care for older adults.

Section 9. Comparative Analysis of the History of Geriatric Mental Health Services in Florida versus Other States

Florida has long maintained one of the highest proportions of older adults of any of the states in the nation. Although state data on the demographics of older Floridians has been collected routinely for several years, the prevalence of geriatric mental health issues in Florida has not been rigorously recorded.

Large-scale surveys of the prevalence of mental disorders in the U.S. were initiated in the 1980s. However, these survey reports do not appear to categorize results according to state. The prevalence of mental illness was first measured by the National Household Survey on Drug Abuse

¹³⁷ Ibid.

(NHSDA) in 2001 for all persons age 18 or older. For state-specific data, the three age groups measured were 12 to 17 years, 18 to 25 years, and 26 years or older. Thus, data on the prevalence of mental illness in Florida in 2001, and in all subsequent years up until the most recent ones, is not available for older adults specifically through SAMHSA reports. Therefore, although national mental illness rates for older adults are available throughout the past decade, Florida rates in particular do not appear to be accessible through SAMHSA. Overall:

The rate of mental disorder, including dementia, in older adults appears quite stable over time. Estimated prevalence in Table 1 is similar to our 22% estimate in 1992 and Jeste et al.'s 19.6% estimate in 1999. Furthermore, the most recent findings are strikingly consistent with those of the Epidemiological Catchment Area survey, collected in 1982-1983. (Karel et al., 2012, p. 185)¹³⁸

Some of the CDC's BRFSS measurements have been analyzed in a series of research reports titled *The State of Aging and Health in America*. These reports have been released in 2004, 2007, and 2013. The mental health parameter that is addressed in these reports is frequent mental distress, defined as having had 14 or more mentally unhealthy days in the previous month. In the 2004 report, 6.3% of persons age 65 or older from 2000-2001 reported frequent mental distress; in Florida, 5.9% reported frequent mental distress, giving Florida a state rank of 16.¹³⁹ In the 2007 report, 6.3% of persons age 65 or older from 2003-2004 reported frequent mental distress; in Florida, 7.0% reported frequent mental distress, giving Florida a state rank of 36, which was quite a change from previous years' rankings.¹⁴⁰ In the 2013 report, 6.9% of persons age 65 or older in 2010 reported frequent mental distress; in Florida, 7.4% reported frequent mental distress, giving Florida a state score within the third quartile relative to all other states.¹⁴¹ It is noteworthy that also in this report, a call to action was issued for addressing mental distress in older adults.

The CDC similarly released a report titled *The State of Mental Health and Aging in America* in 2008. In this report, data from the 2006 BRFSS, which also measured current depression, reveals that Florida was one of the states in which the percentage of adults aged 50 or older who experienced frequent mental distress ranged from 8.53-9.82%, ranking Florida in the half of the states with the higher percentages.¹⁴² This report also shows that Florida was one of the states in which the percentage of adults aged 50 or older who had current depression ranged from 5.42-6.66%, ranking Florida in the half of the states with the lower percentages.¹⁴³ The CDC's Healthy Aging Data Portfolio further reveals that in 2006, for adults aged 65 and older, 5.0% reported current depression; in Florida during this same year, 4.1% of adults aged 65 and older reported current depression.¹⁴⁴

¹³⁸ Karel et al., supra, note 6.

¹³⁹ Centers for Disease Control and Prevention. (2004). *The state of aging and health in America 2004*. Washington, DC: Merck Institute of Aging and Health.

¹⁴⁰ Centers for Disease Control and Prevention and Merck Company Foundation. (2007). *The state of aging and health in America 2007*. Whitehouse Station, NJ: The Merck Company Foundation.

¹⁴¹ Centers for Disease Control and Prevention, supra, note 110.

¹⁴² Centers for Disease Control and Prevention & National Association of Chronic Disease Directors, supra, note 12.

¹⁴³ Ibid.

¹⁴⁴ Healthy Aging Data Portfolio (Online), supra, note 112.

Alzheimer's disease and other dementias have had a substantial prevalence in Florida's older adult population. The Alzheimer's Association has released a series of reports with state prevalence data on Alzheimer's disease. All of the data on these state prevalence projections have been created from Hebert et al. (2004).¹⁴⁵ In Florida, the projected total number of adults age 65 and older with Alzheimer's in 2000 was 360,000; in 2010 it was 450,000; and in 2025 it is projected to be 590,000.¹⁴⁶ The percent change in Alzheimer's (compared with 2000) was 25% in 2010 and 64% in 2025.¹⁴⁷ Thus, Florida ranks in the upper half of the states for the prevalence of Alzheimer's disease percent change (especially given its large older adult population) and it only fell below California in terms of sheer number of individuals with this disease. As previously mentioned, the DOEA records county and state profiles for the demographics of older Floridians. According to these demographics (i.e., the only available measured state geriatric mental health parameters):

- In 1999, the estimated cases of probable Alzheimer's disease was 365,799¹⁴⁸
- In 2000, the estimated cases of probable Alzheimer's disease was 372,375¹⁴⁹
- In 2001, the estimated cases of probable Alzheimer's disease (60+) was 411,367¹⁵⁰
- In 2003, the estimated cases of Alzheimer's disease (65+) was 426,348¹⁵¹
- In 2004, the cases of probable Alzheimer's disease (65+) was 435,263¹⁵²
- In 2005, the probable Alzheimer's cases (65+) was 465,305¹⁵³
- In 2006, the probable Alzheimer's cases (65+) was 479,875¹⁵⁴
- In 2007, the probable Alzheimer's cases (60+) was 487,433, and the disability status (60+) with 1 type of disability, specifically a mental one, was 391,563¹⁵⁵
- In 2008, the probable Alzheimer's cases (65+) was 490,184, and the disability status (65+) with at least 1 type of disability, specifically a mental one, was 398,541¹⁵⁶

¹⁴⁵ Hebert, L. E., Scherr, P. A., Bienias, J. L., Bennett, D. A., & Evans, D. A. (2004). State-specific projections through 2025 of Alzheimer disease prevalence. *Neurology*, 62(9), 1645-1645.

¹⁴⁶ Alzheimer's Association, supra, note 18.

¹⁴⁷ Ibid.

¹⁴⁸ Florida Department of Elder Affairs. (1999). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁴⁹ Florida Department of Elder Affairs. (2000). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵⁰ Florida Department of Elder Affairs. (2001). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵¹ Florida Department of Elder Affairs. (2003). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵² Florida Department of Elder Affairs. (2004). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵³ Florida Department of Elder Affairs. (2005). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵⁴ Florida Department of Elder Affairs. (2006). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵⁵ Florida Department of Elder Affairs. (2007). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵⁶ Florida Department of Elder Affairs. (2008). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

- In 2009, the probable Alzheimer's cases (65+) was 509,493, and the disability status (65+) with at least 1 type of disability, specifically a mental one, was 404,465¹⁵⁷

Also, as previously mentioned, state suicide prevalence rates are available. According the CDC's WISQARS™, the 2004-2010 death rate per 100,000 for fatal injuries due to suicide in the U.S. for the high-risk group of men age 65 and older was 28.92; this rate for men age 65 and older in Florida was 33.52.¹⁵⁸

Overall, extensive updates are needed on the prevalence of geriatric mental health issues in Florida. It can be reasonably expected that such prevalence rates will continue to increase, especially for Alzheimer's disease and other dementias, as the geriatric population in Florida grows.

The use of national mental health services by older adults has remained low.

Underutilization of specialty mental health services by older adults has been true for cohorts of adults 65 years and older for the past few decades. In relatively recent studies, older adults (65+ years of age) with evidence of mental disorder in 1997-1998 and in 2001, reported using specialty mental health services at approximately one-quarter to half the rate of younger cohorts. (Karel et al., 2012, p. 187)¹⁵⁹

The period 1996-2006 also displayed some disturbing trends. For adults impaired by a mental illness, rates of treatment remained essentially constant through 2006; for the elderly, they actually declined. (Glieb and Frank, 2009, p. 646)¹⁶⁰

However:

In recent years, the proportion and number of older adults receiving treatment for depression has increased substantially... Aside from depression, it is not clear that treatment for other MH/SU [mental health and substance use] conditions has increased in general for older adults. (Institute of Medicine, 2012, p. 127-128)¹⁶¹

A consistent trend throughout Florida's history of mental health services is that there is an unmet need for all adults. In 2001, the Florida Commission on Mental Health and Substance Abuse reported:

Despite limitations in our current management system, we can reasonably estimate that annually only about 20% of all children and adults with need for MHSA

¹⁵⁷ Florida Department of Elder Affairs. (2009). *County & state profiles*. Tallahassee, FL: Department of Elder Affairs.

¹⁵⁸ Web-based Injury Statistics and Query Reporting System (WISQARS) (Online), supra, note 24.

¹⁵⁹ Karel et al., supra, note 6.

¹⁶⁰ Glied, S. A., & Frank, R. G. (2009). Better but not best: Recent trends in the well-being of the mentally ill. *Health Affairs*, 28(3), 637-648.

¹⁶¹ Institute of Medicine, supra, note 1.

services receive treatment from DCF providers. (Florida Commission on Mental Health and Substance Abuse, 2001, p. 21)¹⁶²

SAMHSA's Center for Mental Health Services (CMHS) provides Uniform Reporting System (URS) Output Tables, via the National Outcome Measures (NOMS), which reveal statistics on the people served by state mental health services. The data from 2007-2012 detail that:

- In Florida in 2007, 262,917 total clients were served by the SMHA system; there was a 14.53 total utilization rate per 1,000 population, whereas the U.S. rate was 20.14. In Florida, 8,986 of those served were 65 and over. The 65 to 74 age group had a 4.3 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 9.0; the 75 and over age group had a 1.7 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 6.1¹⁶³
- In Florida in 2008, 262,292 total clients were served by the SMHA system; there was a 14.37 total utilization rate per 1,000 population, whereas the U.S. rate was 20.69. In Florida, 8,691 of those served were 65 and over. The 65 to 74 age group had a 4.2 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 8.9; the 75 and over age group had a 1.5 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 6.1¹⁶⁴
- In Florida in 2009, 270,617 total clients were served by the SMHA system; there was a 14.77 total utilization rate per 1,000 population, whereas the U.S. rate was 20.85. In Florida, 9,352 of those served were 65 and over. The 65 to 74 age group had a 4.4 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 8.9; the 75 and over age group had a 1.5 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 6.6¹⁶⁵
- In Florida in 2010, 285,323 total clients were served by the SMHA system; there was a 15.39 total utilization rate per 1,000 population, whereas the U.S. rate was 21.94. In Florida, 9,197 of those served were 65 and over. The 65 to 74 age group had a 4.4 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 9.3; the 75 and over age group had a 1.4 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 7.7¹⁶⁶

¹⁶² Florida Commission on Mental Health and Substance Abuse. (2001). *Final report: January 2001*. Tampa, FL: Florida Commission on Mental Health and Substance Abuse.

¹⁶³ Center for Mental Health Services. (2008). *2007 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁶⁴ Center for Mental Health Services. (2009). *2008 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁶⁵ Center for Mental Health Services. (2010). *2009 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁶⁶ Center for Mental Health Services. (2011). *2010 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

- In Florida in 2011, 294,988 total clients were served by the SMHA system; there was a 15.91 total utilization rate per 1,000 population, whereas the U.S. rate was 22.10. In Florida, 9,865 of those served were 65 and over. The 65 to 74 age group had a 4.7 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 9.0; the 75 and over age group had a 1.5 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 6.9¹⁶⁷
- In Florida in 2012, 319,190 total clients were served by the SMHA system; there was a 16.75 total utilization rate per 1,000 population, whereas the U.S. rate was 22.67. In Florida, 11,070 of those served were 65 and over. The 65 to 74 age group had a 4.7 total utilization rate per 1,000 population, whereas the U.S. rate for this group was 9.0; the 75 and over age group had a 1.7 total utilization rate per 1,000 population rate, whereas the U.S. rate for this group was 7.0¹⁶⁸

Overall, the rate of the utilization of state mental health services for older adults has remained substantially lower in Florida than in the nation at large.

The DOEA also provides several summaries of DOEA programs and services, complete with the units of service. Some of these programs and services are related to mental health:

- According to the 2007 report, there were 213,701 case management units (in hours) (“a client centered service that assists individuals in identifying physical and emotional needs and problems through an interview and assessment process; discussing and developing a plan for services which address these needs; arranging and coordinating agreed-upon services; and monitoring the quality of and effectiveness of the services”), 104,278 companionship units (in hours) (“visiting a client who is socially and/or geographically isolated, for the purpose of relieving loneliness and providing continuing social contact with the community by casual conversation, providing assistance with reading, writing letters, entertaining games”), 18,181 counseling units (in hours) (“uses the casework mode of relating to a client (via interview, discussion or lending a sympathetic ear) to advise and enable the older person and/or their family to resolve problems (concrete or emotional) or to relieve temporary stresses encountered by them”), 1,095 counseling (gerontological) – group units (in hours), 24,743 counseling (gerontological) – individual units (in hours), 1,374 counseling (mental health counseling/screening) units (in hours) (“services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments for persons suffering from a mental illness, including depression and anxiety. These services include specialized individual, group and family therapy provided to individuals using techniques appropriate to this population”), 6,655 health promotion units (in hours) (“offers individual and/or

¹⁶⁷ Center for Mental Health Services. (2012). *2011 CMHS Uniform Reporting System output table*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁶⁸ Center for Mental Health Services, *supra*, note 115.

- group sessions that assist participants to understand how lifestyle impacts physical and mental health and to develop personal practices that enhance total well-being”), 1,885 medication management units (in hours) (“screening, education, identification and counseling regarding the medication regime that individuals are using, including prescription and over the counter medications, vitamins, and home remedies”), 322 mental health screening units (in hours) (“includes information gathering and assessment, diagnosis, and development of a treatment plan in coordination with the client’s care plan”), several Aging and Disability Resource Centers, and the Alzheimer’s Disease Programs¹⁶⁹
- According to the 2009 report, there were 230,306 case management units (in hours), 1,114,621 companionship units (in hours), 18,516 counseling units (in hours), 2,106 counseling (gerontological) – group units (in hours), 23,590 counseling (gerontological) – individual units (in hours), 4,013 counseling (mental health counseling/screening) units (in hours), 5,321 health promotion units (in hours), 3,152 medication management units (in hours), several Aging and Disability Resource Centers, Health Promotion and Wellness Initiatives, and the Alzheimer’s Disease Programs (the Alzheimer’s Disease Initiative)¹⁷⁰
 - According to the 2010 report, there were 219,323 case management units (in hours), 1,039,601 companionship units (in hours), 12,392 counseling units (in hours), 1,914 counseling (gerontological) – group units (in hours), 23,894 counseling (gerontological) – individual units (in hours), 4,561 counseling (mental health counseling and screening) units (in hours), 3,351 health promotion – group units (in hours), 1,219 health promotion – individual units (in hours), 1,075 medication management – group units (in hours), 1,308 medication management – individual units (in hours), 1,880 medication management units (in hours), 54 mental health screening units (in hours), several Aging and Disability Resource Centers, Health Promotion and Wellness Initiatives, and the Alzheimer’s Disease Programs¹⁷¹
 - According to the 2014 report, there were 1,321,786 case management units (in hours), 706,600 companionship units (in hours), 3,726 counseling units (in hours), 1,567 counseling (gerontological) – group units (in hours), 14,671 counseling (gerontological) – individual units (in hours), 325 counseling (mental health counseling and screening) – group units (in hours), 4,973 counseling (mental health counseling and screening) – individual units (in hours), 192 health promotion – group units (in hours), 221 health promotion – individual units (in hours), 150 medication management – group units (in hours), 871 medication management – individual units (in hours), several Aging and Disability Resource Centers, Health Promotion and Wellness Initiatives, the Alzheimer’s Disease Programs, and Healthy IDEAS (“designed to detect

¹⁶⁹ Florida Department of Elder Affairs. (2007). *2007 Summary of programs and services*. Tallahassee, FL: Department of Elder Affairs.

¹⁷⁰ Florida Department of Elder Affairs. (2009). *2009 Summary of programs and services*. Tallahassee, FL: Department of Elder Affairs.

¹⁷¹ Florida Department of Elder Affairs. (2010). *2010 Summary of programs and services*. Tallahassee, FL: Department of Elder Affairs.

and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations”)¹⁷²

Careful monitoring of these services and programs is needed to ensure that there is adequate access to geriatric services.

The first policy change aimed at providing services for older adults was the Older Americans Act of 1965. This legislation established grants for state services, research, and training in the realm of aging, and it also created the Administration on Aging (AoA). Policy specific to geriatric mental health has been lacking at both the national and state levels, despite the problems surrounding geriatric mental health having been identified in the 1999 Surgeon General’s report on mental health, the 2005 White House Conference on Aging, and SAMHSA’s Transforming Mental Health Care in America initiative. Some policies, such as the Medicare Prescription Drug, Improvement and Modernization Act (MMA), the Medicare Improvements for Patients and Providers Act of 2008, and the Mental Health Parity and Addiction Equity Act of 2008, have been beneficial to the geriatric mental health system. However, other policies that could have major impacts on this system, such as the Positive Aging Act and the Caring for an Aging America Act, have not been passed.

Recently, geriatric cognitive issues, especially Alzheimer’s disease, have received more federal and public attention due to increasingly large occurrences and lack of treatments/cures. The National Alzheimer’s Project Act (NAPA) was enacted in 2011 to help develop a national plan to address the Alzheimer’s disease crisis.

Specific geriatric mental health policy in Florida has been deficient. A timeline of the development of the state’s mental health system is as follows:

In 1968, the Florida Constitution was revised and health and social services were assigned to the Department of Health and Rehabilitative Services (DHRS). This newly-created agency was notable in that it represented one of the first attempts nationally to integrate health and human services, and was intended to address the emerging realization that many individuals accessing publicly funded programs and service often had complex health and social needs that weren’t adequately served through categorically distinct programs.

In 1970, the Florida Legislature enacted the Community Mental Health Act to establish ways and means for the distribution of federal funds through the state to community mental health centers.

In 1971, the State Legislature passed the Florida Mental Health Act, which became better known as the Baker Act, to provide due process in involuntary civil commitment proceedings and to establish uniform criteria for people being admitted to state hospitals.

¹⁷² Florida Department of Elder Affairs. (2014). *2014 Summary of programs and services*. Tallahassee, FL: Department of Elder Affairs.

In 1984, the legislature made sweeping changes to the Florida Mental Health Act revising the Baker Act and eliminating the mental health boards, which were replaced with planning councils that had similar planning and evaluation duties but did not allocate funds. (Florida Supreme Court, 2007, p. 17-18)¹⁷³

The DOEA was:

Authorized in 1991 per an amendment to the Florida Constitution, Article IV, Section 12.

Created in the “Department of Elderly Affairs Act,” Section 20.41 and Chapter 430, Florida Statutes. (Beach, p. 1)¹⁷⁴

Then:

In 1996 the Legislature reorganized DHRS, creating a separate Department of Health and creating the Department of Children & Families (DCF). (Florida Supreme Court, 2007, p. 19)¹⁷⁵

In 2000, the Florida Legislature amended Florida’s Mental Health statute, requiring the DCF to revise its target groups for substance abuse and mental health services to include older adults.¹⁷⁶

Funding for mental health services in general in Florida have historically been low. Florida has continuously had one of the lowest per capita mental health expenditures in the U.S.

In Florida, total state mental health appropriations increased from \$219 million to \$370 million between FY96-97 and FY06-07, an increase of \$151 million. When adjustments are made for inflation, total expenditures rose from \$219 million in FY96-97 to \$248 million in FY06-07, an increase of \$29 million. Trends in per capita state appropriations indicate an increase in funding between FY96-97 and FY06-07 from \$14.90 to \$20.10; however when adjusted for inflation, per capita state appropriations increased from \$14.90 to \$17.27 between FY96-97 and FY01-02 and then decreased to \$13.47 in FY06-07, a net loss of \$1.43 per capita across the prior decade. (Florida Supreme Court, 2007, p. 26)¹⁷⁷

¹⁷³ Florida Supreme Court. (2007). *Transforming Florida’s mental health system*. Retrieved from: http://www.floridasupremecourt.org/pub_info/documents/11-14-2007_Mental_Health_Report.pdf

¹⁷⁴ Beach, E. D. *Florida Department of Elder Affairs*. Retrieved from: http://www.myfloridahouse.gov/FileStores/Web/HouseContent/Approved/Minority%20Leader/Resources/Senior_FactSheet.pdf

¹⁷⁵ Florida Supreme Court, *supra*, note 173.

¹⁷⁶ Florida Mental Health Act. Fla Stat §394.9081.

¹⁷⁷ Florida Supreme Court, *supra*, note 173.

In Florida, SMHA Mental Health Expenditures (actual expenditures rather than government appropriation values) have been reported for FY 2004 to 2010:¹⁷⁸

- FY 2004 = \$623,000,000
- FY 2005 = \$647,200,000
- FY 2006 = \$686,600,000
- FY 2007 = \$722,700,000
- FY 2008 = \$768,900,000
- FY 2009 = \$755,300,000
- FY 2010 = \$742,200,000

In Florida in 2005, the SMHA expenditure per capita amount was \$36.56, giving Florida a per capita state rank of 48.¹⁷⁹ In Florida in 2007, the SHMA expenditure per capita amount was \$39.87, giving Florida a state rank of 46.¹⁸⁰ In 2009, the U.S. average for per capita mental health spending was \$122.90; the Florida per capita mental health spending was \$40.90, making it one of the states with the lowest per capita mental health spending.¹⁸¹

State level expenditures for geriatric mental health services alone do not appear to be available. However, state funding for certain DOEA programs that, as previously discussed, address certain geriatric mental health needs are available. Both the Alzheimer’s Disease Initiative (ADI) and the Community Care for the Elderly (CCE) programs provide mental health-related services to older adults. The following tables display year-by-year state funding data for these programs.¹⁸²

For the ADI:

Respite/Special Projects

State Fiscal Year	State Funding	Clients Served
1992-1993	\$2,260,618	1,613
1993-1994	\$2,260,618	1,773
1994-1995	\$2,810,618	2,272
1995-1996	\$3,797,301	2,566
1996-1997	\$4,701,939	2,816
1997-1998	\$6,301,939	3,209
1998-1999	\$7,301,939	3,590

¹⁷⁸ Kaiser Family Foundation. *State Mental Health Agency (SMHA), mental health services expenditures*. Retrieved from: <http://kff.org/other/state-indicator/smha-expenditures/#graph>

¹⁷⁹ Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

¹⁸⁰ Substance Abuse and Mental Health Services Administration. (2011). *Funding and characteristics of state mental health agencies, 2009*. HHS Publication No. (SMA) 11-4655. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹⁸¹ Honberg, R., Kimball, A., Diehl, S., Usher, L., & Fitzpatrick, M. (2011). *State mental health cuts: The continuing crisis*. Arlington, VA: National Alliance on Mental Illness.

¹⁸² Florida Department of Elder Affairs, supra, note 172.

1999-2000	\$7,801,939	3,468
2000-2001	\$7,801,939	3,305
2001-2002	\$7,801,939	3,101
2002-2003	\$7,401,454	2,647
2003-2004	\$7,401,454	2,749
2004-2005	\$10,302,855	2,730
2005-2006	\$9,971,754	2,429
2006-2007	\$10,546,754	2,446
2007-2008	\$10,291,005	2,379
2008-2009	\$9,621,935	2,174
2009-2010	\$8,050,666	1,999
2010-2011	\$8,362,200	2,300
2011-2012	\$9,404,262	3,348
2012-2013	\$9,554,262	1,808
2013-2014	\$10,412,201	#1,970

Projection

Memory Disorder Clinics

State Fiscal Year	State Funding	Clients Served
1992-1993	\$1,864,765	2,561
1993-1994	\$2,169,676	2,534
1994-1995	\$2,978,373	3,140
1995-1996	\$2,964,266	3,579
1996-1997	\$3,078,824	4,203
1997-1998	\$3,078,824	3,794
1998-1999	\$3,645,824	4,920
1999-2000	\$3,834,824	4,832
2000-2001	\$4,223,824	4,900
2001-2002	\$4,223,824	6,314
2002-2003	\$2,912,881	6,134
2003-2004	\$2,912,881	7,328
2004-2005	\$3,793,016	6,884
2005-2006	\$4,039,411	6,103
2006-2007	\$3,286,351	4,872
2007-2008	\$3,416,490	4,745
2008-2009	\$3,254,474	4,716
2009-2010	\$2,968,081	5,116
2010-2011	\$2,968,081	7,096
2011-2012	\$2,968,081	6,732
2012-2013	\$2,968,081	6,886
2013-2014	\$3,413,603	#7,046

Projection

Brain Bank

State Fiscal Year	State Funding	Persons Registered	Autopsies
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1993-1994	\$138,859	82	67
1994-1995	\$138,859	80	84
1995-1996	\$138,201	82	67
1996-1997	\$130,139	100	87
1997-1998	\$130,139	44	66
1998-1999	\$130,139	54	67
1999-2000	\$137,139	82	59
2000-2001	\$130,139	130	90
2001-2002	\$130,139	56	47
2002-2003	\$130,139	56	47
2003-2004	\$130,139	83	74
2004-2005	\$130,139	61	40
2005-2006	\$155,139	55	48
2006-2007	\$130,139	76	72
2007-2008	\$130,139	118	75
2008-2009	\$128,876	159	79
2009-2010	\$117,535	135	80
2010-2011	\$117,535	120	87
2011-2012	\$117,535	129	119
2012-2013	\$117,535	89	69
2013-2014	\$117,535	#93	#70

Projection

Model Day Care

State Fiscal Year	State Funding	Clients Served
2006-2007	\$376,530	101
2007-2008	\$376,530	108
2008-2009	\$372,879	142
2009-2010	\$340,065	130
2010-2011	\$340,065	110
2011-2012	\$340,065	113
2012-2013	\$340,065	115
2013-2014	\$340,065	#115

Projection

For the CCE:

Appropriation History & Numbers Served

State Fiscal Year	State Funding	Clients Served
1992-1993	\$36,082,001	36,462
1993-1994	\$36,270,000	27,700
1994-1995	\$38,660,000	30,990
1995-1996	\$41,471,224	38,827
1996-1997	\$41,158,448	41,990
1997-1998	\$38,818,253	38,564

1998-1999	*\$33,891,064	35,580
1999-2000	**\$45,038,164	40,338
2000-2001	\$46,933,055	40,804
2001-2002	\$43,451,823	37,296
2002-2003	\$43,451,823	34,476
2003-2004	\$43,446,823	34,986
2004-2005	\$43,446,823	33,909
2005-2006	\$44,106,823	32,470
2006-2007	\$47,106,823	28,485
2007-2008	\$43,364,370	19,232
2008-2009	\$41,521,133	15,773
2009-2010	\$40,578,617	16,165
2010-2011	\$40,479,617	16,015
2011-2012	\$40,479,617	13,459
2012-2013	\$41,479,617	14,244
2013-2014	\$45,229,617	#15,728

*Balance reflects \$3,007,562 transfer to the home and community-based waiver program, creating \$6,807,519 in federal and General Revenue funds available for waiver-eligible clients.

**Reflects \$1,761,646 transferred to the home and community-based waiver.

Projection

Overall, spending on geriatric mental health care, especially in Florida, has failed to meet the need for services and the gap appears to be growing.

Section 10. The Future of Aging and Mental Health

Assessing and improving the geriatric mental health system is critically important. Continued research on the diagnosis, etiology, prevention, and treatment of mental illness in older adults is beneficial in numerous aspects. As this research is conducted, additional consideration for not only the comparative efficacy, but also the safety of different geriatric mental health interventions/treatments should be promoted. Karel et al. (2012)¹⁸³ states:

Large-scale longitudinal studies are needed to learn more about the history of mental illness as people grow old; that is, what happens to individuals with early or midlife psychiatric illness as they grow older, and which adults are most likely to develop mental health problems for the first time in late life?

Psychologists must continue to evaluate the implications of technologies that allow for earlier diagnosis of or clarification risk for dementia and other aging-related illnesses. (Karel et al., 2012, p. 194)¹⁸⁴

¹⁸³ Karel et al., supra, note 6.

¹⁸⁴ Ibid.

Dementia research, especially on Alzheimer's disease, must continue to receive attention and funding. The effects of Alzheimer's disease are widespread and devastating, and as of now, there is no cure for this illness.

None of the treatments available today for AD slows or stops the death and malfunction of neurons in the brain that cause AD symptoms and make the disease fatal. However, dozens of drugs and therapies aimed at slowing or stopping brain cell death and malfunction are being studied worldwide. (Alzheimer's Association, 2013, p. 214)¹⁸⁵

*The Healthy Brain Initiative: The Public Health Road Map for State and National Partnerships, 2013-2018*¹⁸⁶:

... Outlines how state and local public health agencies and their partners can promote cognitive functioning, address cognitive impairment for individuals living in the community, and help meet the needs of care partners. (Alzheimer's Association and Centers for Disease Control and Prevention, 2013, p. i)¹⁸⁷

This report lists specific actions to be addressed in the public health sectors and also emphasizes the mechanisms through which to translate research findings into practice. This roadmap provides a great framework for improving the geriatric mental health system in regard to dementia.

As previously discussed, prevalence data on mental disorders in older adults remains heterogeneous and elusive. Updating the national and state data collection systems so that more accurate prevalence and utilization of services rates for this population can be obtained will allow for the geriatric mental health system to be better informed. Researchers, health care providers, and policy makers can then react to improve efficiency.

Future research requires a larger database on the epidemiology of mental disorders in the elderly. Furthermore, an improvement to the methodology that addresses the challenges of older age and produces comparable data, including the use of instruments tailored to the needs of older people, is required. (Volkert et al., 2013, p. 339)¹⁸⁸

Greater attention to cohort differences in various populations of older adults could also benefit the efficacy of the geriatric mental health system. Available services and policy should reflect these differences accordingly.

¹⁸⁵ Alzheimer's Association, *supra*, note 18.

¹⁸⁶ Alzheimer's Association and Centers for Disease Control and Prevention. (2013). *The healthy brain initiative: The public health road map for state and national partnerships, 2013–2018*. Chicago, IL: Alzheimer's Association.

¹⁸⁷ *Ibid.*

¹⁸⁸ Volkert et al., *supra*, note 16.

... Compared with earlier cohorts of older adults, baby boomers may be more open to reporting mental disorders as they grow older, and they may be potentially less resilient in the face of aging-related medical, functional, and financial stress.

Although the cohort of adults now turning 65 years old may be more likely to perceive a need for mental health care when experiencing symptoms of a mental disorder, they are still significantly more likely to seek and accept services in primary care versus specialty mental health settings. (Karel et al., 2012, p. 186-187)¹⁸⁹

As the older adult population continues to age and expand, the demographics of this population will evolve; the subsequent changes in relation to aging and mental health need to be understood.

... As the oldest of the baby boomers age, the age distribution will shift, with an increasing percentage of the older population being over 80 years old. Because the 'oldest-old' typically require more frequent and more intense care than the 'young-old,' the changing age distribution of the older populations has many implications for the health care workforce. (Institute of Medicine, 2012, p. 25)¹⁹⁰

The Institute of Medicine (2012)¹⁹¹ also predicts that between 2010 and 2030, the ethnic, racial, and cultural makeup of the geriatric population will become more diverse than ever before. This diversification increases the need for multicultural competency in geropsychology.

Efforts to disseminate information on the differences between normal and abnormal aging in regard to cognition and mental health should be expanded. Education of adults of all ages on this matter could lead to increases in preventative and diagnostic actions. Additionally, efforts to reduce ageism and stigma associated with mental illness could result in better access to necessary mental health services. There are gains as well as losses throughout the life-span, and many older adults live very happy, healthy, and productive lives. Maintaining a positive attitude and perception on aging can sustain mental health and quality of life.

Increased funding for the geriatric mental health system, and the mental health system in general, is critical. Increased funding could allow for greater research and outreach interventions, more high-quality geriatric mental health services, and a stronger geriatric mental health workforce.

The need for improved training of geriatric health providers, so that mental illness can be readily acknowledged, assessed, and treated, and a larger size of this workforce will only continue to intensify as the geriatric population grows.

The committee recommends that both Congress and the Health and Human Services Secretary act to invigorate investment in the human capital that is the geriatric MH/SU workforce, to catalyze basic system redesign to allow for effective deployment of geriatric MH/SU personnel, and to stimulate essential research to

¹⁸⁹ Karel et al., *supra*, note 6.

¹⁹⁰ Institute of Medicine, *supra*, note 1.

¹⁹¹ *Ibid.*

inform the education and training of personnel and workforce planning itself. (Institute of Medicine, 2012, p. 283)¹⁹²

The five specific recommendations to improve the geriatric mental health workforce that are outlined in the Institute of Medicine (2012)¹⁹³ include:

1. Congress should direct the Secretary of Health and Human Services (HHS) to designate a responsible entity for coordinating federal efforts to develop and strengthen the nation's geriatric MH/SU workforce.
2. The Secretary of HHS should ensure that its agencies-including the Administration on Aging (AoA), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration (HRSA), National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), and Substance Abuse and Mental Health Services Administration (SAMHSA)-assume responsibility for building the capacity and facilitating the deployment of the MH/SU workforce for older Americans...
3. Organizations responsible for accreditation, certification, and professional examination, as well as state licensing boards, should modify their standards, curriculum requirements, and credentialing procedures to require professional competence in geriatric MH/SU for all levels for personnel that care for the delivery of older adults.
4. Congress should appropriate funds for the Patient Protection and Affordable Care Act (ACA) workforce provisions that authorize training, scholarship, and loan forgiveness for individuals who work with or are preparing to work with older adults who have MH/SU conditions. This funding should be targeted to programs with curricula in geriatric MH/SU and directed specifically to the following types of workers who make a commitment to caring for older adults who have MH/SU conditions...
5. HHS should direct a responsible entity (as described above) to develop and coordinate implementation of a data collection and reporting strategy for geriatric MH/SU workforce planning. (Institute of Medicine, 2012, p. 12-15)¹⁹⁴

Initiating incentives for professionals to enter the mental health field, and especially the mental health field related to geriatrics, could aid in the expansion of a quality mental health workforce.

Overall, access to geriatric mental health services needs to be increased. Employment of safe and effective evidence-based practices to treat geriatric mental illness should be advanced. Models of care, especially models that emphasize collaborative efforts, are especially promising. Effectively treating geriatric mental illness not only produces positive health, social, and economic outcomes,

¹⁹² Ibid.

¹⁹³ Ibid.

¹⁹⁴ Ibid.

it can also reduce the risk of suicide in this age group. According to a National Alliance on Mental Illness (NAMI) (2009)¹⁹⁵ report:

Depression is the single most significant risk factor for suicide in the elderly population. Tragically, many of those people who go on to die by suicide have reached out for help-20 percent see a doctor the day they die, 40 percent the week they die and 70 percent in the month they die. (National Alliance on Mental Illness, 2009, p. 1)¹⁹⁶

Early recognition, diagnosis, and treatment of geriatric depression and other mental illnesses, especially by primary care physicians, could help to combat the high frequency of suicide in older men. Raising the public awareness of suicide in older adults could also aid this process. Implementation of relevant evidence-based practices such as PROSPECT (Prevention of Suicide in Primary Care Elderly: Collaborative Trial), an effective, community-based model of care implementing case management for reducing suicide ideation in older adults with depression, are critical.

Innovative options to increase access to geriatric mental health care, including telemedicine opportunities (e.g., computer-based psychotherapy programs), should be explored.

Because many older adults and caregivers are not able to access the physician's or psychologist's office, due to inability to drive or poor access in rural areas, the potential of telephone and online video technologies to help in the diagnosis of problems and the treatment of older adults is promising. (Karel et al., 2012, p. 191)¹⁹⁷

Medicare Part B now covers certain telehealth services that are relevant to mental health.

More information is needed on how to effectively expand geriatric mental health services to various at-risk geriatric subpopulations.

Research on effective delivery of MH/SU care for individuals residing in nursing homes and other residential settings, prisoners, rurally isolated elders, and older adults with severe mental illnesses is urgently needed. (Institute of Medicine, 2012, p. 241)¹⁹⁸

The movement toward integrated care is especially prominent for the geriatric population. Primary care is the setting in which in most older adults typically receive health care. Continued collaborative efforts between primary care providers and mental health providers will be critical for the state of the geriatric mental health system. More funding is needed to strengthen the training required for primary care providers to recognize and diagnose geriatric mental health problems and to then refer the applicable patients to appropriate mental health services.

¹⁹⁵ National Alliance on Mental Illness, *supra*, note 45.

¹⁹⁶ *Ibid.*

¹⁹⁷ Karel et al., *supra*, note 6.

¹⁹⁸ Institute of Medicine, *supra*, note 1.

The quality of the available geriatric mental health services needs to be addressed. The Agency for Healthcare Research and Quality (AHRQ) has no specific focus on geriatric MH/SU.¹⁹⁹ Better measurements, especially patient-centered outcomes, are needed to assess the current state of these services. Comparative effectiveness research on the various services should also be conducted to allow for a more efficient system overall. The quality of geriatric mental health services, especially in nursing homes, requires improvement.

In addition to comparative effectiveness research, comparative cost-effectiveness research is critical. As the implementation of evidence-based interventions and especially models of care increases, the comparative evaluation of such services against one another can allow for a more efficient geriatric mental health system. Since funding is limited, cost-effective approaches can permit greater utilization of the restricted services.

Relatedly, updated policy is needed to protect older adults' access to mental health services under increasing budget pressure.

Mental health parity should facilitate increased access to psychological services for older adults; however, ongoing fiscal pressures to reduce Medicare reimbursements may be a disincentive for psychologists to consider geropsychological practice. (Karel et al., 2012, p. 189)²⁰⁰

A reduction in the frequency of psychiatrists accepting Medicare has already been noted.

Bringing geriatric mental health care to the forefront of national concern and encouraging the collaboration between state mental health departments and state departments that handle aging issues, and even Area Agencies on Aging (AAAs), will hopefully lessen the chances that this critical issue to be overlooked.

Section 11. Conclusion

The U.S.'s geriatric mental health system is of vital importance, especially as the population of older adults continues to grow. The gravity of this issue has been highlighted at the federal, state, and local levels. Support for assessing and addressing the geriatric mental health system has recently gained momentum. Other positive changes include increased findings on the efficacy of interventions to sustain mental health throughout the aging process and subsequent outreach to disseminate such information, continuous improvement in the understanding of the etiology and presentation of geriatric mental illness, advancements in treatment options, implementation of evidence-based practices, increased attention to the study of dementia, parity for mental health services, expansion of mental health and substance use disorder coverage, and emphasis on the integration of health care. State mental health budgets are also improving as economic standings progress.

¹⁹⁹ Ibid.

²⁰⁰ Karel et al., *supra*, note 6.

However, the U.S.'s mental health system, and accordingly the geriatric mental health system, is still critically underfunded. There is also an increased need for access to quality geriatric mental health services. Some of the barriers to the U.S.'s geriatric mental health system include lack of recognition and diagnosis of geriatric mental illness, especially in primary care settings, deficiency of geriatric utilization of specialized mental health services, mental health services remaining expensive, unsuccessful assessment of geriatric mental health services/care and system performance, fragmentation of the service delivery system, and an inadequate workforce of trained geriatric mental health providers.

The condition of the geriatric mental health system is especially important in Florida, as a state that contains one of the largest numbers and proportions of older adults. Although recent positive efforts have been made to better assess and address the needs of older Floridians, inadequacies remain in the state geriatric mental health system. Florida has notoriously lagged in funding for mental health services. Expansion of expenditures on mental health services in general, with particular consideration for geriatric mental health services, is critical. Additional research and consequent supportive policy on comparative effectiveness and cost-effectiveness of geriatric mental health services might provide the opportunity for more efficient spending of the limited resources. Recommendations for the movement toward a more effective geriatric mental health system include support for the investigation of comparative cost-effectiveness of available geriatric mental health services, implementation of frameworks designed to improve the ability to measure quality of geriatric mental health care, development of and reliance on patient-centered outcomes, expansion of integrated care, application of evidence-based models of integrated care (e.g., IMPACT), continued collaborative efforts between the Department of Children and Families and the Department of Elder Affairs, and strengthening of the geriatric mental health workforce (e.g., through initiating financial incentives for geriatric mental health providers, standardizing training requirements, and emphasizing multicultural competency). Continued improvement of the geriatric mental health system will provide numerous health, social, and economic benefits.